		1 For	riease			nd / Depa	artment of	Health a		-	_	ole.	00001
		Registrar				Cei	rtificate of	t Death	1		No. 🚄 🔱	U4	UZUUI
	Physician	1. Decedent's Name (Fil							M		Day	Yeer	3. Time of Death
	/Medical	GARI		OCKLE						AN. 26	,200		12:06 a ^M
	Examiner	JOSEPH R	-				4b. City, Town,				4c. County		
		5. Social Security Numb				. last birthday)	If Under 1 Yea	TIMOR		ite of Birth		J/A 9. Birthi	place (Stete or Foreign
	Funeral Director	215-46-96		X M 2□F		6 Yrs.	Months Day		Min. MA	te of Birth conth, Day, Ye Y 22, 1	947	N. (place (Stete or Foreign ntry) CAROLINA
		Usual Residence of Dec											
nylan	how		. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
e Ma	1-8	MD.	N/A		B	ALTIMO	ORE						XXYes 2 □ No
d 21215-0036 filed within 72 hours after death with the Maryland	ral; or itams 23a or 28a-1 ehow Examiner must be notified at the Funeral Director	10e. Street and Number					10f. Zip Code			10g.	Citizen of \		ntry?
ta v	1 23a	1405 CUR	IE WAY				212				U.S.		and Indian
er de	r itams 23e	11. Marital Status	OFF Massical	Armed Fo		0.5.	Was Decedent of If Yes, specify Cu	i Hispanic Origi Iban, Mexican,	Puerto Rican,	es or No- etc.)		ck, White,	
136 rs aft	P. A.			1 ☐ Yes If Yes, Gir Year or D	ve sates:		1 ☐ Yes 2 🂢 N	o Specify:			Specify	у.	ERICAN
-00-	"natural", adical Exp		Decedent's Ed	lucation		16a. Dece	dent's Usual Occ	upation		166	. Kind of B	IND] usiness/In	
215 7 nin 73	ygiene. ner than "naturalit, the Medical i	(Specify of Elementary/Secondar	nly highest gra	de completed) College (1-40r 5+)	(Give	kind of work don DO NOT use retir	ne during most (red)	of working				
212 d with	Hygiene other than ant, the	4	, (0 12)	Conego (1 401 017	FIE	ELD HAN	ID		F	'ARMI	NG_	
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Maryland 21215-0036	and Mental Hygiene. Is marked other than sumatic event, the M. To Re Comp.	JUNIORS	LOCKL	EAR				DOI	LA HU	JNT			
lar 2 sho	th and Mer 7 is mark traumatic	19a. Informant's Name/				19b. Mailir	ng Address (Stree	et and Number	r or Rural Roul	e Number, Ci	ty or Town,	State, Zij	o Code)
	Health tem 27 other tra	MARTIN HUI	<u> </u>	THER	look	204 E	BARHARB	OR ROA	AD, PAS	SADENA	, MAR	YLAN	ID 21122
2 Ofe Baltimore,	5 = 5	20a. Method of Disposit 1 Deurial 2 CC		Removal from	State		sition (Name of matory or other pi		Date		Location -	City or To	own, State
917 = =	tant: jury	°4 □Donation 5 □	Other (Specify	1)	BA		CREMAT			BA	LTIM	ORE,	MARYLAND
2 Balt	Department Important: any injury o	21. Signature of Funera	I Sorrice Licen	500	1	22	LLY &	ress of Facility ZEILEI	R INC.	FUNE	RAL	HOME	E
~	U. = 6 0	- Care		010	ALL S	10	01 EAS	TERN Z	AVENUE	BALT	O.,M	D	21231
190		23a. Part1. Enter the di shock, or heart fai		one cause on e	aused the dea each line.					iratory arrest,			Approximate Interval Between Onset and Death
	ysician	Immediate Cause (Fina disease or condition resulting in death)		a. 59 U	amous	cell ca	ncer of	the to	orque				2415
4 E	Medical caminer	resulting in oddiny	(Due to	(or as a conse	quence of):			0				1
- CV		Sequentially list condition	ons,	b	(ur as a consu	cuenos =f)						_	
to to	ial-transit	Sequentially list condition is any, leading to immediate. Enter Underlyin Cause (Disease or injur	g d		,	400,100 017							
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360, 760,	S S			ч									
68 ifical	attendir g physi												
Box	use use	IF FEMALE: 23b. Was decedent pre	gnant	23c. If yes, ou	tcome of pregr		Ectopic pregnan				23d. Da	te of deliv	,
Geatl	d by the attending phyletached for use as the	in the past 12 mon 1 ☐ Yes 2 ☐ No			nant at time of		Other (specify)				Mo	onth	Day Year
P.O. Patthe	igned by the c	9 ☐ Unknown		9LI UNKN	own								
lear rds, P.O	gue d		t conditions c	ontributing to d	eath but not re	sulting in the u	nderlying cause g	given in Part I.	2				the cause of death?
ord ordina	been si									1 🗆 Yes	2 🗆 No	3 Prot	bably 4 DUnknown
OCKIC al Records,	20 0									4a. Was an autopsy	2 1	prior to co	opsy findings available impletion of cause of
X # #	page page								11	performed ☐ Yes 2 1	No	death? 1 🔲 Yes	2 V No
Vital Vital	certificate rector, pag	25. Was case referred	6 medical						of Death (Che	ck only one)	,		11
of \	this o	1 ☐ Yes 2 No				ER/Outpatier	IL 3 DOA		sing Home 5				n) Hospice
_ 6	ath. or: After this certifica e funeral director, p	27. Manner of Death	Pending		of Injury th, Day Yeer)	28b. Time of Injury	W			escribe how in	njury occur	ed	1180
ARY ivision or Attending	4 - 4	2 ☐ Accident 3 ☐ Suicide 6	investigation Could not be		of lainer Att	home form at		□Yes 2□N		cation (Stran	and Alumb	or or Dur	al Route Number,
Φ NiC A P	rs after death al Director: ed in by the	4 🗌 Homicide	determined	build.	ing, etc. (Spec	cify)	eet, factory, office	е	261. CC	ity or Town, Si	ate)	er or nure	ar noute realities,
() alg	neral filled	29a. Certifier 10	Cartifying Ph	vsician: To the	hest of my kr	nowledge deat	n occurred at the	time date and	I place, and du	e to the cause	a(s) and ma	anner as r	tated
, in	4139	(Check only 2 one)		niner: On the b			vestigation, in my						
ro th	within 2 To the I complet	29b. Signature and title	of certifier				29c. Licer	nse number		29d.	Date signe	d (Month,	Day, Year)
	2. 0) Gto	0 11	W			1	72417	70	lan	Wan.	26.2	204
M. Ker	,	30. Name a_d address	of person who	completed çau:	se of death (Ite	am 23a) (Type,	Print)	1		J.)11	July 2	0,2	70 1
	/	E. Tso Mi	- 01	cher H	ospi ce	838	Nitrut)2417 awst	Balt	imore	MI	> 2	1201
MIN	State		lay, Year)		legistrar's Sigr	nature							
	Registra	JAN 2 8 2	2004 -	Little Brown	15	100	a der						
DHMH	17 Rev 1/200	1	/		/	1							

ORIGINAL

DHMH 17 Rev 1/2001

ORIGINAL

		1- For State Registrar		laryland / Dep		Health and M Death	•	ne 2001	+ 0200;
Physic /Medi	cal	Decedent's Name (First, Middle, La Julia Eubank Mall As Essility Name (If not institution of	ory	1	dh Ch Taur		lanuary	24 04	3. Time of Death 23:52PM
Exami	ner	Social Security Number	Health iex 7.A	ge (In yrs. last birthda	Balt			4c. County of Dea	thplece (State or Foreign
Director		214-50-0227 Usual Residence of Decedent 10a. State 10b. County	□M 2 X F	88 Yrs.		S AOUIS WIIII.	July 14,		rginia 10d. Inside City Limits
ith the Marylar or 28a-f show	Director	Maryland n/a 10e. Street and Number		Baltim	ore 10f. Zip Code		10g. (Citizen of What Co	1 ☐ Yes 2 ☐ No buntry?
er death w Items 23a	Funeral C	2147 Wilkens Aven 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces 1 Yes 2	No	2122 Was Decedent of If Yes, specify Cul	3 Hispanic Origin? (Spe ban, Mexican, Puerto I	city Yes or No- Rican, etc.)	United 14. Race - Ame Black, Whi	
Maryland 21215-0036 to 2 should be filed within 72 hours alt the and Mental Hygiene. 77 is marked other then "natural", or traumatic event, tre Medical Exert.	Completed by Funeral	3 X Widowed 4 □ Divorced 15. Decedent's Ending of the state of the s	If Yes, Give A Year or Dates:	16a. Dec	1 Yes 2 No	ipation	ng 16b.	Specify: M	Thite Tindustry
ind 2121 be filed within tal Hygiene. d other then "	Be Comp	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last,	College (1-4or	5+)	omemaker	,	(First, Middle, Maide	home en Sumame)	
Marylan: 12 should be h and Mental 7 is marked of traumatic eve	J.	Charles Waddey 19a. Informant's Name/Relationship (1		Emiswort	l Route Number, City		
Baltimore, Mi permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra once.		George W. Mallory 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	20b. Place of Disp	position (Name of ematory or other pla	ace)	ate 20c.	Location - City or	Town, State
Balti permit. Departm imports eny inju		21. Signature of Funeral Service Licer	lsee K		22. Name and Addr 1107 Wilke	^{ess of Facility} Hubl ens Avenue	bard Funeı . Baltimon	cal Home	Maryland Inc. Land 21229
Physician /Medical		23a. Part1. Enter the dispase, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Re	spirator	y Failu		respiratory arrest,		Approximate Interval Between Onset and Death Hows
Examiner le be executed e pruisi-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated avents resulting in death) Last	c	a consequence of): Diment a consequence of): a consequence of):	La				Years.
	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	sy		23d. Date of del Month	ivery Day Year
Q Records, P Records, P Records, P Records, P Records Record		Part II. Other significant conditions of	ontributing to death t	out not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobacco		the cause of death?
	Completed						24a. Was an autopsy performed? 1 Yes 2 X N	prior to o	topsy findings available completion of cause of 2 No
- 4	ion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatii 28a. Date of Inju (Month, Da	rv 28b. Time	of 28c. Inju	ry at 2	(Check only one) ie 5 Residence 8d. Describe how injuly		sify)
VISI Atten or deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, farm, s ic. <i>(Specify)</i>		Yes 2 No	8f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
Di To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	one)	ysician: To the best niner: On the basis of and manner st	it examination and/or i	nvestigation, in my	me, date and place, a opinion, death occurre	nd due to the cause(d at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
To with To COM	2	29b. Signature and title of certifier Racuel Shill)	29c. Licens	se number 15627 Baltumor		ate signed (Mont)	
\0	to	30. Name and address of person who a Rachel Tuom 31. Date filed (Month, Day, Year)	as 90	leath (Item 23a) (Type Cator) ar's Signature	Ave 1	Baltumor	emo 2	21229	
Registr		JAN 2 8 2	nna ba	and the second	1	A. A.			

			1 = For State Registrar			nd / Depa		t of H	lealth and N	ental Hyg		2001	02006
	- ¥		Decedent's Name (First, Middle, L	ast)						2. Date of Dea	th		3. Time of Death
	Physic		Elsie B. Mear	S						January	23	2004	8:45PM
	/Medi Examir		4a. Facility Name (If not institution, g		m <i>ber)</i>		4b. City, 1	Town, or	Location of Death	J Carrage J	_	unty of Death	0.132
			Gilcrest				To	wso	n		В	altimo	re
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24 Hrs.	8. Date of Birth			place (State or Foreign
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Director		214-40-5586	1 ☐ M 21X F	10	1 Yrs.	Months	Days	Hours Min.	Aug. 6,	1902	Mary	land
L di	P		Usual Residence of Decedent										
73	show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City Limits
300	Ba-f	cto	Maryland Howa	rd		E1:	licott	: Ci	ty				1 □ Yes 2√⊡1No
0/	iih tr or 2	Director	10e. Street and Number				10f. Zip			1		of What Cour	ntry?
W	ath w	-ca	4519 Montgom					.043			U.	S.A.	
01/23/04 @	72 hours after death with the Maryland naturel', or items 23s or 28s-(show licel Examiner must be notified at	Completed by Funeral	11. Marital Status	Armed Fo		I.S. 13.	Was Decede If Yes, speci	ent of Hi fy Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
- 36	s afte	Y.	1 ☐ Never Mamed 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	/8		1 ☐ Yes 2	ĭ∆ No	Specify:		Sp	ecify: TJh	ite
01/	hour fural	pa t pa	15. Decedent's	Year or D	ates:	16a Dogg	dost's Havel		tion	1	101 161-1		
215	in 72	Set	(Specify only highest g	rade completed)		(Give	kind of worl	k done d e retired	ation furing most of work)	ing	16b. Kina (of Business/In-	dustry
4 —	the the	E	Elementary/Secondary (0-12)	College (1	1-4or 5+) 2		cher				Educ	ation	
2 5	filed Hyg other	Be C	17. Father's Name (First, Middle, Las						18. Mother's Name	(First, Middle, I			
4 5	id be ental	To B	George Blann						Alvertie	Barnes			
MeARS	shound M	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	nd Number or Run	al Route Number	City or To	wn. State. Zip	Code)
	nd 2 Lith a 27 is		Garland E. Mear	s (Son))	1.	_		58 Altamo				,
فِ	s 1 a f Hea f Hea othe		20a. Method of Disposition	······································	20b. F	Place of Dispo cemetery, cren				Contract of		on - City or To	
1SIE Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Department of Heath 27 is marked other than "natural", or filema 23a or 28a-f ahow any injury or other traumatic event, the Modical Examination and the notified at once.		1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec		State	adowria		ier piace	" 1–27-	2004 E	lkrid	ge, Mai	cvland
S H	artm oorta inju		21. Signature of Funeral Service Lice		1		_	Addres					
	Depa impo any is		E Ser - al	17	men	W:	itzke 630 Fá	Fun	s of Facility eral Home	of Cato	onsvi.	lle, In	nc. and 21228
ω			23a. Part1. Enter the disease, or con shock, or heart failure. List on	nplications that c	aused the deat							rial y La	Approximate
	Physician		Immediate Cause (Final	y one cause on e									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	or as a conseq	MON ON	11/1				-,		weeks
	Examiner				or 25 a corrseq	derice (i).							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ————————————————————————————————————	or as a conseq	uence of):							
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	C									
o.	be executician and burial-trai		resulting in death) Last	Due to (or as a conseq	uence of):							
760.	9 × 6	cal		d									
99	ntifica ng ph	Ved	IF FEMALE:										
õ	th ce tendi	an/	23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pre	gnancy			23d.	Date of delive	*
. E	ed for	SICI	in the past 12 months?		ant at time of d		Other (spe				1	Month	Day Year
9	that the death certifica ed by the attending ph detached for use as th	Physician/Med	9 Unknown		-								
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certifica death. Geath. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	by	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the ur	nderlying car	use give	n in Part I.		,		e cause of death?
ord	w requires to been signers should be	ted	Demented							1 🗆 Ye	s 2 12 N	o 3∏Proba	ably 4 Unknown
ပို	has by	pfe				~				24a. Was ar autops	24	b. Were autop	osy findings available appletion of cause of
<u> </u>	ding Physician: The In. After this certificate he Inneral director, page	Completed								perform	ned?	death?	
/ita	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						26. Place of Death				
7	Physi this c	ဥ	1 ☐ Yes 2 No			ER/Outpatien	t 3 DOA	Othe	r. 4 🗆 Nursing Hor	ne 5 🗆 Reside	nce 6	Other (Specify	Hospice
<u></u>	ding F h. After funera	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	28	c. Injury Work	at :	28d. Describe ho	w injury oc	curred	/
sio	Attendii death. ctor: A y the fu	catl	2 Accident investigate 3 Suicide 6 Could not	00			М		es 2 □ No				
Ξ	l or Attendater death Director:	E	4 Homicide determined	28e. Place	of Injury - At ho ng, etc. (Specify	ome, farm, stre	et, factory,	office	1	28f. Location (Str City or Town	eet and Nu , State)	mber or Rural	Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in	<u>ల</u> ి	an a w										
6	Hos 24 ho Fun Fun	lica	29a. Cartifier 1 ★ Certifying P (Check only one) 2 Medical Exe	miner: On the ba	isis of examina	wledge, death tion and/or inv	occurred at restigation, i	t the time n my op:	e, date and place, a inion, death occurre	and due to the ca ad at the time, da	use(s) and ite and plac	manner as sta ce, and due to	ated. the cause(s)
	the sple	Medical	29b. Signature and title of certifier	and mann	er stated.			License				ned (Month, E	600
	5 W P P		MA M	DR		1	100		205	17 000			4, 2004
	h		11 MVThen	y me	y in	J						mya	1,2007
	.5		30. Name and address of person who		of death (Item	1 23a) (Type, I	Print)	۲	Balto. r	Nd 212	208		
	Sta	to	31. Date filed (Month, Day, Year)		egistrar's Signa		ار وب	•					
	Registr		JAN 2 8 20	6.27	rece A	? Los							

			r State of Marylar Fire 827 Marylar	nd / Depa		lealth and	Mental Hyg		4 0200
Physic /Med		1. Decedent's Name (First, Middle, Last	mASSIE				2. Date of Deat Month	Day Yee	3. Time of Death
Exami		4a. Fecility Name (If not institution, give NORTHWEST HO	street and number) SPITAL CENT	ER .	4b. City. Town, o	r Location of Deal	1 N	4c. County of De	MORE.
Funeral Director		5. Social Security Number 224–36–0207 10			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. E	irthplece (State or Foreign Country) VA
/land low		Usuel Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10d. Inside City Limits
e Man ta-feh	Director	MD NA	Bal	ltimore	=				1 X Yes 2 □ No
with th		10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
leath ns 23	Funeral	3510 Hillsmere	Road 12. Was Decedent Ever in U	I.S. 13 W	as Decedent of H	207_ lispanic Origin? (S	Specify Yes or No-	U.S.	Δ nencan Indian,
hours after death with the Maryland turel; or Itams 23s or 28s-1 show al Exercises must be collibed at	۵	XXNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	11	Yes, specify Cuba □ Yes 2🌠 No	Specify:	to Rican, etc.)	Black, Wi	
d within 72 hours after death with the Marylan jiene. r than "naturel", or Itams 23a or 28a-f ehow the Medical Exercine me must be molfited at	Completed	15. Decedent's Edd (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give k	ent's Usual Occup and of work done of ONOT use retired	during most of wo	rking	6b. Kind of Busines	ss/Industry
nd 2 should be filed within 72 hours af Ith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exprin	Be Con	12th Grade 17. Father's Name (First, Middle, Last)	8yrs	Tea	acher	18. Mother's Nar	ne (First, Middle, M		chool Syst
d Men	2	Abraham L. Mass				Mary At	kinson		
permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 2002.		Marcellus L. Ma 20a. Method of Disposition	ssie-Nephew		Bremis		, Gaith	City or Town, State ersburg Oc. Location - City	Md 2087
ages ant of I it: If its y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F * 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crema	atory`or other plac	tery1/3			
permit. P Departme Importan any injur		21. Schature of Funeral Servic Licens		Mar	Name and Addres	ss of Facility West	Baltim	Lexingto	on, VA 21215
Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	NEUM	the mode of dyin	g, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
be executed icien and burial-transit	ical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	il death 3 □E	ctopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
w requires that s been signed b should be deta	þ	Part II. Other significant conditions co.		ulting in the und	erlying cause give	en in Part !.			to the cause of death?
sician: The law re- certificate has bee rector, page 2 sho	Completed	CONGESTIVE	HEART J	FAILU	28.			prior to death? No 1 \subseteq Ye	
ysicia s certi directo	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe	26.	th (Check only one) ce 6 □Other (Sp	aniful
or Attending Physician: after death. Director: After this certifics in by the funeral director. I	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how		вспу)
at or Atte s after des of Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree y)	t, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death o tion and/or inve	occurred at the tim stigation, in my op	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	is stated. se to the cause(s)
To the To	M	29b. Signature and the of certifier	PHYSICIAN		29c. License	4 27 8	13. JA	d. Date signed (Mor	ath, Day, Year) 26 2004
10		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Pr	int) NC	RTHW	EST FO		L CENTE
St. Regist	- 5	31. Date filed (Month PN. 19ar 8 20	04 32 Aegistrar's Signa	tura.	Whi.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 2004 5:45 P M **Physician** DON MOSES, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 12 M 2□ F Director 8/9/1922 VTRGINIA 224-26-5201 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ? is marked other than "natural", or Itams 23a or 28e-f ahov traumatic event. The Medical Ever in that he is clifted at 1 ☐ Yes 2 ☑ No Director PARKVILLE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 1803 COBOURG COURT APT. T2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CROWN CORK & SEAL College (1-4or 5+) Elementary/Secondary (0-12) MACHINIST 12TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be I nent of Health and Mental I WILLIE A. SMITH DON MOSES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) pernit. Pages 1 and 2: Deportment of Health at Important: If item 27 is any injury or other trau BERNADINE TAGLIVIA SISTER-IN-8334 RIDGELY OAK RD. BALTIMORE, MD 21234 206. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MOST HOLY REDEEMER CEM. 1/29/04 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21286 8521 LOCH RAVEN BLVD. TOWSON, MD Park . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ineumonia Zweeks **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of): Examiner as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 - Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation neral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel c within 24 hours af To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0043489 MD 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Brian J. Bohman, MD N, Charles 601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oocks Registrar IAN 2 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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MAMA WAS A
31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

South!

O.C.M.E.

JANUARY 25,2004

111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND ITEM #8 PER FH G827 1/29/04 JiCertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** McNeal Kenneth TANUARY ZOOY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** PRITIMORE 7.4M.4RITAR 405PITAL 8. Date of Birth 3-14-19669. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 XM 2 □ F 37 Md. Director 213-78-8911 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other then "natural", or items 23a or 28e-f shov treumatic event, it a Miculcal Examinar must be not find at 1X Yes 2 □ No Md. Baltimore Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 USA Apt. 303 2525 Eutaw Pl. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Etementary/Secondary (0-12) Never Worked NA 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Smith Luvenia McNeal William 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2525 Eutaw Pl Apt. 303, Baltimore, Md. 21217 Mother Luvenia McNeal injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Importent: If eny injury or once. * 4 □ Donation 5 □ Other (Specify) Mt. Zion Cem. 1 - 23 - 04Lansdowne, Md. 21. Signature of Funeral Service Licensee 21202 22. Name and Address of Facility Md. Baltimore. March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final ALSY WITH COMPLICATIONS **Physician** EREBRAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D58570 JANUARY 23 ZUOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601, LOCH RAVEN BOSLEVARS AKER BALTIMIRE, MD X1239 TERRANGE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 8 2004 Registrar

			1 - For State Registrar	State of M	laryland		artmen rtificat					giene Reg. No. 2	2004	02010
	Physici	an	Decedent's Name (First, Middle, La	•							2. Date of Dea		O O Year	3. Time of Death
	/Medi	cal	Mary	<u>C.</u>		Mog	avero		Lasabias		January		2004	10:20 P™
	Examir	ner	4a. Facility Name (If not institution, given Genesis Hamilton						Location of			4c. Co	unty of Deati	n
Ý	Funeral				ge (In yrs. lasi	t birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birti	h ,		hplace (Stete or Foreign untry)
	Director		256-18-4118	1□M 2XF	88	Yrs.	Months	Days	Hours	Min.	(Month, De) July 27	, 1915	Geo	orgia
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation							10d. Inside City Limits
	Aaryk Sho	ŏ	Maryland N/A				ore C	itv						1 X Yes 2 □ No
	28e-	Directo	10e. Street and Number				10f. Zip					10a. Citizen	of What Co	untry?
	h with	ID IS	3121 Mary Aven	ue				2121	4			-	U.S.A.	•
	deat erm	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Deced	dent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
36	s after	by Fu	1 Never Married 2 Married	1 Tes 2 X		1	1 □ Yes			,, , , , , , , , , , , , , , , , , , , ,	110411, 010.7			hite
Ö	72 hours after death with the Maryland natural', or Items 23a or 28e-1 show dical Examinar trust be motified at		3 X Widowed 4 ☐ Divorced	Year or Dates:	1	6a Dece	dent's Usua	al Occupa	tion				of Business/I	
15	n na	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)		(Give	kind of wo	rk done d se retired)	uring most	t of workii	ng	700. Killa	OI DUSIII 1933/I	ndustry
212	giene giene er tha	Completed	12 yr's	College (1-4or	3+)	Ho	me Ma	ker					0wn	Home
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other traumatic event, the Medical Evantian maritie for inclining an once.	To Be (17. Father's Name (First, Middle, Last James	Grady	Chasta	in				r's Name Luby	(First, Middle,	Maiden Sui Pearl	,	Carlisle
, Mar	and 2 sho palth and p 27 is mu er trauma		19a. Informant's Name/Relationship (Dauc	inter-		ng Address 1 Mar				nore, M		own, State, Z 214	ip Code)
ore	of He of He If iten		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	l com	e of Dispo etery, crer	sition (Nan natory or o	ne of ther place)	D	ate	20c. Locati	ion - City or 1	Town, State
ţ	t. Pag timent rtant:		* 4 ☐ Donation 5 ☐ Other (Speci	(y)			Hill				26,2004			
Bal	Depariment of the pariment of		21. Signature of Funeral Service Lice	nsee	b		. Name an			Du	ltimore			
-			23a. Pert1. Enter the disease, or com	plications that cause	of the death.		eonar						ford F	Approximate
2	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each		SVE	0	7	en	See A	1'a		16	Interval Between Onset and Death
te.	/Medical		disease or condition resulting in death)	a. Due to (or as	s a consequen	-			200	W/V	1000			2-5-60.
	Examiner		Sequentially list conditions.	b										
7	pe is	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce of):								
2	sate be executed oblysicien and the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as	a consequen	ce of):								
8760	sicier sicier			4									1	
Ø	ifficate g phy as the	edlo		_ u.										
Вох	The law requires that the death certificate be executed tte has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pr	egnancy				23d.	Date of deliv	
O.	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (sp						Month	Day Year
P.O.	that the	Phy	Part II. Other significant conditions	contributing to death t	out not resultin	na in the ur	nderlying c	alise Give	n in Part I		23e Did to	bacco use o	contribute to	the cause of death?
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COL	w req beer shou	lete		-1							24a. Was a	n 24	4b Were aut	opsy findings available
Re	The lav te has age 2 t	dwo									autops	med?	prior to co death?	ompletion of cause of
ital	ysicien: The is certificate hadirector, page	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only or	2 PNo	1 🗆 Yes	2 1 No
>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☑ Mo	Hospital: 1 Inpati	ent 2 ER	/Outpatien	t 3 🗆 DO	Othe			ne 5 Resido		Other (Speci	ify)
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Division of Vital Records,	itel or At	Certification:	4 Homicide determined	building, e	tc. (Specity)						City or Town	n, State)		al Route Number,
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_	p		30. Name and address of person who	ASBBM		(Type, 1999) (Type, 1999) (Type, 1999)	Print)	TRA	2~1	BLI	VD.	MD	~ 2	1221
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Registrar

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			1 - For State Registrar	State of N	//arylar	nd / Depa		t of H	ealth a	and M			2001.	02012
	Diam'r.	,	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month		V Voor	3. Time of Death
	Physici /Medio		James R. M	organ, J	r.						Januar	У	20,2004	4 9:26p
	Examir		4a. Fecility Neme (If not institution, gi	ve street and numbe	er)		4b. City,	Town, or	Location of	of Death		4c	County of Deet	h
			University 0		nd		В	alti	imore	9			N/A	
	Funeral			Sex 7. A XIXM 2□ F		last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	1 00	hplece (State or Foreign untry)
	Director		219-38-4337		61	Yrs.					Sept.	18,1	942 Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Many f sho	ō	Maryland N/A											1. Yes 2 □ No
	the 1	ect	Maryland N/A 10e. Street and Number			Balt:	10f. Zip	-			1	Oa Cit	tizen of What Co	unto/2
	with year	ā	218 S. Vincen	+ C+roo+								-	nited S	
	death ms 2%	by Funeral Director	11. Marital Status	12 Was Deceden	t Ever in II	.S. 13. \		230 lent of Hi	spanic Orio	gin? (Spe	cify Yes or No-	01	14. Race - Ame	
က	r ite	Fur	1 Never Married 2 Married	Armed Forces	s? ∃Ņo.					, Puerto I	cify Yes or No- Rican, etc.)		Black, White	
පු	ef', o	by	3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	Vietn	am	1 ☐ Yes	2 No	Specify:			ŀ	Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28a-f ahow he Madical Examiber must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Deced	dent's Usua	i Occupa	ation	t of working		16b. K	ind of Business/	ndustry
2	thin Mes	nple	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	kind of woi DO NOT us	e retired,)	OF WORK	ng			
7	ygien ygien t, Ing	Con	9			Upho	1ste:	r				Κi	itchen	Furniture
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, Las								(First, Middle, I		,	
<u> </u>	Men Men arke	Jo	James R. Mor						Ma	rga	ret A.	De	ernetz	
<u>a</u>	2 sh and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street a	nd Numbe	r or Rura	l Route Number	City o	or Town, State, Z	ip Code)
2	and leatth m 27 her t		Peggy Morgan	(Daughte					eet			•	4D 2122	
Baltimore,	t of H t of H if ite		20a. Method of Disposition Y Burial 2 □ Cremation 3 (☐Removal from Stat		Place of Dispo cemetery, cren	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Lo	ocation - City or	Town, State
<u>=</u>	men tant: jury		*4 □Donation 5 □Other (Spec		MD	Vetera	n Cem	eter	У		/2004		wnsvill	
3all	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show says injury or other treumatic svent, the Madical Examiner must be notified at ance.		21. Signature of Funeral Service Lice	nsee			. Name an							rvice, P.A
_	₹ 0 = 0		23a. Part1. Enter the disease, or cor	ramue	unn								imore,	MD 21225
	Physician /Medical Examiner /Medical pe panial-fransit	Ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bue to (or as a consequence of): Lethal Dysrhythmia Due to (or as a consequence of): Lethal Dysrhythmia Due to (or as a consequence of): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy										
.O. Box 68	that the death certificate be executed the by the attending physicien and detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetel	Ideath 3	Ectopic pre		7/81:		ii		23d. Date of delin	very Day Year
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Records,	w requires to been signer should be co		Hypertensio	n							1 □ Ye	s 2[□No 3 ⊠ Pro	babiy 4 🗆 Unknown
ပ္တ	s bee	Completed	Lung Cancer								24a. Was a		24b. Were aut	opsy findings available ompletion of cause of
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<u>ra</u>		BeC	25. Was case referred to medical						26 Place	of Death	(Check only on		1 🗆 Yes	2 NO
⋝	ys dil	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	tient 2	ER/Outpatient	t 3 DO	A Othe					6 □Other (Spec	(fv)
0	<u>a</u> + <u>ra</u>	n: T	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inj (Month, Date	jury	, 28b. Time of Injury		Bc. Injury Work			8d. Describe ho			37
<u></u>	Attending r death. ector: Atter	atlo	2 Accident investigation	n	u) / cu//	mjury	М		es 2□N	10				
Division of Vital	I or Atten after deatl Director: I in by the	Certification:	3 Suicide 6 Could not to determined	286. Place of in	njury - At ho	ome, farm, stre	et, factory,	office		2	8f. Location (Sti City or Town	eet and State	d Number or Rui	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by		29a. Certifier 1 Certifying P	hysician: To the best	t of my know	wiedne Aeath	occurred a	t the time	n data and	1 01000 0	nd due to the ea			
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Exa	miner: On the basis of	or examinal	tion and/or inv	estigation,	in my opi	inion, death	h occurre	d at the time, da	iuse(s)	place, and due	to the cause(s)
	Athin Comp	Me	29b. Signature and title of certifier	1	-//	/	29c.	License	number 7723		29	d. Date	e signed (Month,	Day, Year)
-			1/1/2/	X	11	2			//23 52221	7	т.	้ลทา	lary 2/	1, 2004
	111		30. Nome and a reas of per on who	complet tuse of	ath (Item	23a) (Tyna F	1	-,2(0	ailt	uary Z ²	1, 2004
	17		Fermin Barruet		6 18		•	C+			/280 F	20.1		MD 21230
40	Sta	e_	31. Date filed (Month, Day, Year)		trar's Signa		000	SUL		JULL	2 200 1	ai	CIMUTE	NID 21250
× 1/2	Registr	- 2	JAN 2 8 20	04		e de								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland /		artment tificate			and M		giene Reg. No.	200	L	02013
ì	Dhysia	ion	1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea	ath Day	· v	ear	3. Time of Death
	Physici /Medi		Catherine Ba	rbara	MALINO	WSKI					Januar	y 23	200		10 40P M
	Examir	ner	4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death		4c.	County of	Death	
			2954 Hutton Road					0ak1					Gar	ret	
	Funeral		5. Social Security Number 6. S	ex 7.Ag □M2XTXF	e (In yrs. last t	oirthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day AUG •	h Year)	9	. Birthpl Count	ace (State or Foreigr XYLAND
	Director		215-16-0519 Usual Residence of Decedent	- AA	88	TIS.					AUG.	9,19	915	MAI	RYLAND
	and #		10a. State 10b. County		10c. City, To	wn or Lo	cation							10	d. Inside City Limits
	Many	ò	MD. GARRE	րդ		OAK	LAND								1 ☐ Yes 2 🛣No
	288	Director	10e. Street and Number				10f. Zip	Code				10a. Citi	zen of Wha	t Count	rv?
	3a or	□	2954 HUTTON R	חער				215.	50			_	S.A		,
	death	Funeral	11. Marital Status	12. Was Decedent		13. \	1			gin? (Spe	cify Yes or No- Rican, etc.)		14. Race -		in Indian,
ဖွ	or the	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 [X]			_			, Puerto	Rican, etc.)	1	Black,	White, e	tc.
93	ref., c	<u>\$</u>	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2	. X i No	Specify:				Specify:	VHI'	ГE
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Ind other than "naturel", or flems 23a or 28a-f show event, the Markeal Examitrer, ust be notified at	Completed by	15. Decedent's Ed (Specify only highest gra		16	a. Deced	lent's Usua kind of won	Occupa	tion	of worki	na	16b. Ki	nd of Busin	ess/Ind	ustry
2	within jene.	du	Elementary/Secondary (0-12)	College (1-4or 5		life. L	OO NOT us	e retired)	g		.9				
	filed w Hygier other th	Ö	4		I	IOUS	EWIF	E					DOME	STI	<u> </u>
Ē	be fill H dot	Be	17. Father's Name (First, Middle, Last)								(First, Middle,				
<u>~</u>	2 should be filled within and Mental Hygiene. Is marked other than eumatic event, the M	မ	THOMAS KOUTZ						RO		NIEMI				
Maryland	12 st h and 7 Is n reun		19a. Informant's Name/Relationship (I Route Numbe				
	s 1 and 2 should if Health and Mer Item 27 is marke other treumatic		RICHARD MALINO 20a. Method of Disposition	WSKI/SON	20b. Place				KST.		D, BALT				
Baltimore,	m 0		1 Burial 2 ☐ Cremation 3 ☐		cemet	ery, cren	natory or ot	her place	·		100		cation - Cit		
ij	t. Partmer		' 4 □Donation 5 □ Other (Specify		ST. S						29/04	BAL'	LIMO	RE,I	MARYLAND
Ba	permit. Page Department of Importent: If any injury or once.	1	21. Signature of Funeral Service Licen	A Bore	æ.	LI	LLY 0 S.	& Z.	\mathtt{EILE}	R II	NC. FU	NERA BA	AL HOLTO.	OME , MD	. 21224
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	the death. Do	not ente	er the mode	of dying	, such as	cardiac o	r respiratory ar	est,			Approximate Interval Between
	Priysician	10	Immediate Cause (Final disease or condition	1911	en	1	(10	-	· cin					13	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):									,
	Lxammer		Sequentially list conditions,	b										7	n
	ed sit	lne lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classas or injury that initiated events	Due to (or as	a consequence	∍ of):									
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to for as	a consequence	of):									
8760,	ate be ex hysician the buria			Due to (or as	a consequence	9 OI).									
87	physicate sthe	edlcai		d										-	
9 x	ding se as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy										
Вох	eath certific attending p	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deat		Ectopic pre					2	3d. Date of Month		/ Day Year
o	The law requires that the death certificate ite has been signed by the attending phys page 2 should be detached for use as the	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown	time or death	3 [Oliter (Spe	Cily)							
P.0	that the		Part II. Other significant conditions of	ontributing to death be	ut not resulting	in the un	derlying ca	use give	n in Part I.		23e. Did to	bacco us	se contribu	te to the	cause of death?
of Vital Records,	uires sign	d by						_			1 T	es 2[]No 3[] Probai	oly 4 ⊠Unknown
Ö	w requir been s should	Completed									24a. Was a		24h Wor	a auton	sy findings available
Re	The larate has	Ē							_		autop	SV	prior	to com	pletion of cause of
a		ပိ	OF Man ages referred to modical								1 ☐ Yes	2 💢 No	1 🗆	Yes 2	[XNo
⋚	Physician: 1 this certifical ral director, p	00	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only or		70		No. 10
ō	Phy r this ral d	5	1 ☐ Yes 2 🔀 No		nt 2 ER/C	Time of		1	4 🗆 1901		ne 5 🔀 Reside 8d. Describe he			Specify)	Hospice
0	ding F. After funer	tou	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	Year)	Injury	м	c. Injury Work'	es 2 🗆 N			,,	00001100		
Division	r Attending er death. rector: Atter by the funer	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	urv - At home, f	arm, stre					8f. Location (S	reet and	Number o	r Rural i	Route Number
á	effer effer Dire	Certification:	4 Homicide	building, etc	c. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				City or Town	n, State)			
	To the Hospitel or Attenwithin 24 hours efter deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physical Example 2 Medical Example 1	/sicien: To the best of iner: On the basis of	examination a	je, death nd/or inv	occurred a estigation, i	t the time	e, date and nion, deat	d place, a	nd due to the c	ause(s) a	and manne place, and	r as stat	ed. he cause(s)
	the the trible	Med	29b. Signature and title of certifier	and manner sta	ned.		290	License	number		1 0	9d. Date	signed (M	onth D	av Yearl
,	- 3 + 8			, -	/					0	-				
			1/0/					L	2656	0			1/26/	2004	+
			30. Name and address of person who o						A 7 .						
	IV		Dr. Roger Lewis. 31. Date filed (Month, Day, Yeer)		berry (ar's Signature	Lini	c Te	erra	Alta	We.	st Virg	inia	267	64_	
	Sta Registr		JAN 2 8 2004	Jenetra			,								
DHI	MH 17 Rev 1/20			a diperior	19	de	parks								
	1107 1/21	JU 1			,	/	- 1414	pr							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 25^{Dey} FRANCIS NELSON Jan. 2004 5:47 PM 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death 834 WOODS ROAD PASADENA ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 12 19 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Days 1 M 2 □ F 217-12-1855 Yrs 80 MARYLAND 1923 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ANNE ARUNDEL 1 Yes 2 No **PASADENA** 10f. Zip Code 10g. Citizen of What Country? 21122 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 ☐ No If Yes, Give Year or Dates: WHITE 1 Yes 2 No Specify. Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) FURNITURE STORE 0 Furniture Refinisher Upholsterer 18. Mother's Name (First, Middle, Maiden Surname)

with the Merylend 10a. Stete permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryler Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Hema 23a or 28a-f ahow any injury or other traumetic event, the Medical Examiner must be not a edited. MARYLAND Funeral Director 10e. Street end Number 834 WOODS ROAD 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 <u>م</u> 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12 17. Father's Neme (First, Middle, Last) MILLS ALOYSIUS NELSON EMMA KATHERINE 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE HAZEN (DAUGHTER) 104 MAPLE AV ENUE, PASADENA, MARYLAND 21122 20b. Place of Disposition (Name of 20a. Method of Disposition GLEN HAVEN MEMORIAL PARK 1/31/2004 GLEN BURNIE, MD. 1 Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MgCULLY-POLYNIAK FUNERAL HOME 3204 MOUNTAIN ROAD, PASADENA, Man 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical

Examiner

ig physician end es the buriel-trensit

To the Hospital or Attending Physician: The lew requires that the death certificate be examined to have start death.

To the Funeral Director: After this certificate has been signed by the extending physician ecompletely filled in by the funeral director, page 2 should be datached for use as the bundel.

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

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Physician

/Medical

Examiner

Funeral

Director

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Months Due to (or es a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

MEYERS

20c. Location - City or Town, State

P.A MARYLAND 21122

1 Yes 2 No 3 Probably 4 Unknown

29d. Date signed (Month, Dev. Year)

2106

2004

				_			24a. Was an autopsy performed?	24b. Were autopsy finding available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case refer	red lo medical				26	Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 🕠	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpetient	3□ [OOA Other:	I ☐ Nursing I	Home 5 Aesidence 6 □Othe	or (Specify)
27. Manner of Deet 1 Detural 2 Accident	h 5 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurr	ed
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci		et, facto	ory, office		28f. Location (Street and Number City or Town, State)	er or Rurel Route Number,

State

Registrar

nahish 31. Dete filed (Month, Dey, Year)

29b. Signature end title of certifier

32. Registrer's Signeture

JAN 2 8 2004

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

arkam

305

29c. License number

9505

DHMH 16 Rev 6/95

ORIGINAL

Hos

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician Year Roosevelt Nelson Jan 22 22:40 /Medical 2004 4a Facility Name (If not institution, give street end number) 4b. Çity, Town, or Location of Death Examiner 4c. County of Deeth BALTIMURE VA Medical JALTIMOR e If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) 12 22 Birthplace (Stete or Foreign Country) **Funeral** XXM 2 F Months Days SC 71 Director 249-46-1999 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haaith and Mantal Hygiana. Important: if Item 27 is marked other than "naturel; or ferms 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits Director 1 XYes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5405 Nelson Ave 21215 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? ▼ ▼ Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th grade na Self Employed Janitorial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmitt Nelson Albertha Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 5405 Nelson Ave, Baltimore Md Nellie Nelson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 1/29/04 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical oneumoni weeks Examiner Due to (or as a consequence of): Examiner erebroverscular or Attending Physician: The law requiras that tha death certificata be executed after death. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due td (or as a consequence of): cord Physician/Medical (an Dression for usa as atelectasi Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ģ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Aftar this certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ION GREENE STREET BALTIMORE, MD 21201 Bryan 31. Date filed (Montal), 2º48 2004 32 Registrer's Signature ALAC. Registrar

DHMH 16 Rev 6/95

			1 - For Amend Item #8,16						giene Reg. No. 200				
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La: Mary Dolores O'D Security Name (If not institution, given Saint Joseph	onnell street and number)	Center	4b. City, Town, o	or Location of De	2. Date of De Month JANUA ath	Day Year RY 23, 201	24 2:35 PM			
e,	Funeral Director		Social Security Number Contract	ex 7. Age	e (In yrs. last birthd Yrs	Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birt in. (Month, Da		irthplece (State or Foreign Country) Maryland			
	r 28a-1 show	rector	10a. State 10b. County Maryland N?A 10e. Street and Number		10c. City, Town of Baltimore	Location 10f. Zip Code			10g. Citizen of What (10d. Inside City Limits Yes 2 □ No Country?			
36	iges 1 and 2 should be tiled within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28s-1 show or other traumatic avent, the Medical Experimental by multier and or other traumatic avent, the Medical Experimental and or other traumatic avent, the Medical Experiment	by Funeral Director	4020 Wilsby Avenue 11. Marital Status **X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2XXN If Yes, Give Year or Dates:	Ever in U.S. 1	21218 3. Was Decedent of Hif Yes, specify Cub 1 Yes XX No	Hispanic Origin? an, Mexican, Puo Specify:	(Specify Yes or No- erto Rican, etc.)					
Maryland 21215-0036	filed within 72 hou Hygiene. other than "natura ent, the Medical E	Completed I	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	lucation de completed) College (1-4or 5-	in	cedent's Usual Occupive kind of work done DO NOT use retire	pation during most of w d) Secreta		16b. Kind of Busines	s/Industry Insurance			
ıryland	2 should be filt and Mental Hy Is marked oth sumatic sven	To Be	17. Father's Name (First, Middle, Last) Charles Richard O'Donn 19a. Informant's Name/Relationship (1)	nell	19b. Ma	ailina Address (Street	Agnes	ame (First, Middle, Haydock Bural Boute Numbe	Maiden Surname) r, City or Town, State,	Zin Codel			
	Pages 1 and 2 nent of Health a int: If item 27 is iry or other trau		Rosalie M. O'Donnell 20a. Method of Disposition 1	Sist	er 4020	Wilsby Avenusposition (Name of plantary or other plantary)	e Baltimo		d 21218 20c. Location - City o	r Town, State			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Significant of Funeral Service Licen		kes-		ss of Facility M	itchell-Wie	Baltimore, defeld Funera timore, Maryl	al Home Inc.			
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	a. RESPIR Due to (or as a	the death. Do not e. RATORY F a consequence of): ATION FIN a consequence of):	AILURE	ng, such as cardi	ac or respiratory ari	rest,	Approximate Interval Between Onset and Death			
0k 1949 189	cate be axed and bhysicien and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	,	consequence of):	BSTRUCTI	ON						
P.O. Box 6	The law requires that the death certificate be 3 ate has been signed by the attending physicien page 2 should be detached for use as the burris	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	′		23d. Date of de Month	olivery Day Year			
Records, P	w requires that the de been signed by the should be detached	ted by Pł	Part II. Other significant conditions of CONGESTIVE HEA		23e. Did to	bacco use contribute t	o the cause of death? robably 4 Unknown						
Vital Rec	ysicien: The law is certificate has bi director, page 2 st	e Completed	25. Was case referred to medical				00 Pl		sy prior to death? 2 No 1 Ye	utopsy findings available completion of cause of 2000			
DIVISION Of VI	ng Ph fter th meral	To B	examiner? 1 Yes 2 No 27. Manner of D ath 1 Natural 5 Pending investigation		y 28b. Time	of 28c. Injur	er: 4 🗆 Nursing		ence 6 Other (Spe	ocity)			
Ž O	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	. (Specify)	street, factory, office	ne date and class	City or Town	·				
	To the Ho within 24 h To the Fur completely	Medical	(Check only 2 Medicel Examone) 29b. Signature and title of certifier	iner: On the basis of e and manner stat	examination and/or	investigation, in my o	pinion, death occ	curred at the time, d	ate and place, and du	e to the cause(s)			
	17		30. Name and address of person who d	completed cause of de	ath (Item 23a) (Typ		Ø263		01-23	04			
	Sta Registr												

			For State Registrar		5	State of	f Mary	land .	•	artmen rtificate				lental Hy	Reg. No		04	02017
	Obvertate		1. Decedent's Name	e (First, Middl	e, Last)									2. Date of De Month	aath Da	у .	Yeer	3. Time of Death 2:34 AM
2	Physicia /Medic		Jun					01:	iver					Janus		3,200	-	2.34 AM
	Examin	er	4a. Facility Name (I	_	64		mber)	- 0 -				Location		10	40	. County o	f Death	
			Com	SAMA			tospi			If Under		MAX	24 Hrs.		45	NA	0. Diate	Jane (Chate on Foreign
	Funeral		5. Social Security N		6. Sex 1. ☑ M	1 2 F	7. Age (In 73	yrs. last	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)	,	Cour	* *
100	Director		250-44-2 Usual Residence of				7.5							6-22-	-30		S.	C
and	*		10a. State	10b. County			100	c. City, T	Town or Lo	cation							1	0d. Inside City Limits
X	t t	lo	Md.]	NA				Ba	altimo	ore							1X Yes 2 ☐ No
the	or 28a-f show	Director	10e. Street and Nu	mber						10f. Zip	Code				10g. Ci	tizen of W	nat Cour	ntry?
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de at	The same	Funerai	11. Marital Status		12.	. Was Dece	edent Ever	in U.S.	13.	Was Deced	lent of Hi	spanic Or	rigin? (Sp	ecify Yes or No Rican, etc.)	0-		- Amend	can Indian,
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	To the Hospital within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier (Check only one)	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.											e cause(s e, date ar	s) and mar nd place, a	ner as s nd due t	stated. o the cause(s)
	withir To If comp	Me	29b. Signature an	d title of certifi	er					29	c. Licens	e number			29d. D	ate signed	(Month,	Day, Year)
			> Jh	no Jeh	- N	M					US	000			Jai	nuary	14	12079.
	10		30. Name and Ido	dress of person	who com	npleted cau	ise of death	n (Item 2	3a) (Type	Print)	Bu	D, 1	Acti	mont	M	\$ 2	123	9
	Sta Regist		31. Date filed (Mo	nth, Day, Yea	0 20	32.1	Registrar's	Signatui سنگ ماهریس	re	6	2000	in s	*					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #18 PER FH G828 2/09/04 Grentificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** January POWELL 1133 AM 23,2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth NORTHWEST HOSPITAL KANDALL STOL RANDAL Ush BALTIMORE 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) Months Days Min. 1 ☐ M 2 🕏 F 79 Yrs. Director 212-22-7298 FEB. 27, 1924 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2649 LAURETTA death Funerai AVE USA 14. Rece - American Indian, Black, White, etc. 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes. 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: AFRICAN þ 3 X Widowed 4 □ Divorced AMERICAN 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ASHLEY MILLER ASHBY MILLER WILLIE MAE VANDIVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n eny injury or other traun GLORIA DANIELS (DAUGHTER) 2649 LAURETTA AVENUE BALTIMORE, MARYLAND 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 29, BALTIMORE, MD BALTIMORE NATIONAL TAN 2004 21. Signature of Funeral Service License WYLIW FUNERAL HOME PA 22. Name and Address of Facility 638 N. GILMOR STREET BALTIMORE, D 21217 Approximate Interval Between Onset and Death MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Tyes Completed 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Division of Vital 1 Yes 2/XX10 1 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.
To the Funeral Director: Atter this continue 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 1 ☐ Yes 2 XX io 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury s after dec. 5 Pending investigation 1 Yes 2 No М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29a. Certifier Medical mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

30. Name and

31. Date filed (Months Day).

address of person who

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32 Aggistrar's Signatur

Randallstown

Kd

			For State Registrar			Departme		and Mental H	lygiene Reg. No. 200	4 02019
			Decedent's Name (First, Middle, La	st)				2. Date of	Death	3. Time of Death
	Physici		ANNE MULLER PU	RCELL.				JANUA	Py 24 200	. 1 1 7/ (314
	/Medio Examir		4a. Facility Name (If not institution, giv)	4b. Ci	y, Town, or Location	of Death	4c. County of D	eath
			GOOD SAMARITA	N HOSPI	ITAL	BA	LTIMOR		NA.	
	Funeral		Social Security Number 6. S	6ex 7. A	ge (In yrs. last b	Month	ler 1 Year If Under s Days Hours	Min. (Month,	Day, Year)	Birthplace (State or Foreign Country)
	Director		215-34-6738		91	Yrs.		6/19/	1912 MA	RYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location				10d. Inside City Limits
	Mary	ŏ	MD BALTI	MORE	TOWS	SON				1 ☐ Yes 2 🕅 No
S	1 the	Director	10e. Street and Number		1	10f.	Zip Code		10g. Citizen of What	Country?
611	h witi	a D	6921-D DONACHIE	ROAD			21239		USA	
Ĭ(1)	deat	ner	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. Was De		igin? (Specify Yes or n, Puerto Rican, etc.)	No- 14. Race - A Black, W	merican Indian, hite, etc.
₹ %	or lt	J.	1 Never Married 2 Married	1 Tes 2 T	χVo		20 No Specify:		Specify:	WHITE
, A ~~√ 5-0036	172 hours after death with the Maryland "naturel", or Iteme 23a or 28a-f ehow adical Examinat must be nytitled at	Completed by Funeral	3 Vidowed 4 □ Divorced 15. Decedent's E	Year or Dates:		a. Decedent's U	eual Occupation		16b. Kind of Busine	
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lar C	should be and Mental I smarked o	To	E. LESTER MULLE	R			MAR	GARET JACK	SON	
YORCHE, Maryland	s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic		19a. Informant's Name/Relationship	•					mber, City or Town, State	e, Zip Code)
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ore ore			20a. Method of Disposition 1 XBuriai 2 Cremation 3 D	☐Removal from State	e cemet	tery, crematory of	r other place)		20c. Location - City	
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Baltimore.	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Lice	nsee	ha				SON FUNERAL	
		12	23a. Pant . Enter the disease, or con	polications that cause	ed the death. Do		LOCH RAVE			21286 Approximate
	7 🍇		shock, or heart failure. List only Immediate Cause (Final	one cause on each	di∩e.		,			Interval Between Onset and Death
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മ്	atter after of for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No		2 Fetal dea at time of death		pregnancy (specify)		Month	Day Year
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	s that	by P	Part II. Other significant conditions	contributing to death	but not resulting	in the underlyin	g cause given in Part	I. 23e. D	id tobacco use contribute	e to the cause of death?
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2	ing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b Day Year)	. Time of Injury	28c. Injury at Work?		be how injury occurred	
Division of Vital Records.	ttend death itor; / the f	Certification:	2 Accident investigate 3 Suicide 6 Could not	be 200 Place of I	njury - At home,		1 ☐ Yes 2 ☐		n (Street and Number o	Rural Route Number.
Ž.	or A after Direction by	ertif	4 Homicide determined		etc. (Specify)	141111, 3(1901, 140	tory, ornoe		Town, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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	the I	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. License number		29d. Date signed (M	onth, Day, Year)
	Twin V		255. Signature and title of certifier	Oir	4.0	ě l	RESO			
	/1		30. Name and address of person who	oca i C	death (Item 22	a) (Type Print)				247004
	0		0	ALIK C	100D S	AMAR 1	TAN HUST	PITAL BA	UTMERE, A	10-21239
	St	ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature		1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Physician senee Sarray 12-550 -004 /Medical 20 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** Genera maryland ta 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** 217-90-663 Usual Residence of Deceder 1 M 2 F Yrs. Director 10a. State 10b. County 10c. City, Town or Location # show 10d. Inside City Limits item 27 is marked other than "natural", or Itama 23a or 28a-f shov other traumatic event, the Medical Examiner must be conflict at 1 Kes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 AUENUE . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 25 Ho Specify: yack 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Elementary/Secondary (0-12) ollege (1-4or 5+) eur ryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 462 H Daughter 304 Virginia Beach, VA. Baltimore, 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation Date 20c. Location City or Town, State 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses (do:MO 23a. Part1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner The law requires that the death certificate be executed 10N AR Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68768 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ₩ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Phyaician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Yes 2 No 1 K Inpatient 2 ER/Outpatient 3 DDA this 27. Many er of Death Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred after death. Director: After Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Positiving Physician: 10 lite best of my knowledge, death occurred at the time, date and place, and due to the vade(s) and manner as stated.

/2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type_Print) CHAKARMI MORY

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Physiciar /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturst", or Items 23s or 28e-1 show any injury or other traumatic svent, Ite Medical Exertit er marker rediffied at ORCE.

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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	4	For Amend	8	Unnend	Item	#1.23	3a.27	28a f	per	me	G828	2710	704	tas	8

1. Decedent Name (First, Michiell, Late) 1. CLARENCE B, PAUL JR. 1. Facility have gifted individual, pow street and number/ 1909 DIVISION STREET 2. Social Security Name (Paul Security Name (Paul Security Name) 2. Social Security Name (Paul Security Name) 3. The security Name (Paul Security Name) 3. Social Security Name (Paul Security Name) 3. The security Name (Paul Security Name) 3. The security Name (Paul Security Name) 3. The security Name (Paul Security	aul 1- ^{For} Amend Registrar	l & Unpend	State of Ma	aryland / D , 23a, 27,	epa 28a Cer	rtment of h	ealth and G828 2 Death	Mental Hy 10/04 t	giene as Reg. No. 2	04	0202
CLARENCE B. PAUL JR. 1909 Division Street Secul Secul Manuary 216-86-6462 1907 May F. 7. Age (in yrs. seatcherosy) 100. Cay, Town or Location 100. Speed and Number 100. Speed and Number of Number Number of Number of Number of Number of Number of Number of Number Number of Number Number of Numbe	1. Decedent's Name	(First, Middle, Last)								Vana	3. Time of Death
1909 Dix/Siston Street Social Security Number Social Security Num	CL.	ARENCE B	• PAUL	JR.				Januar	cy 25 20	004	1240 p M
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Transference of December 1900 County 100 City, Town or Location 100 City Town				e (In vrs. last birt)	hday)				th		place (State or Foreign
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BALTHWIRE 100, Glose and Number 100, Glose and N	10a. State	10b. County		10c. City, Town	or Lo	cation				1	0d. Inside City Limits
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To Earner's Name (First, Middle, Marien Summer) CLARENCE B. PAUL SR. GLORIA WONSON 19b. Mailing Address (Street and Number or Arral Router City or Town, State, Zip Code) EDITH SMITH (GRANDMOTHER) 19c. Mailing Address (Street and Number or Arral Router City or Town, State, Zip Code) 11 Survair 2 Chremation 3 Removal from State 12 Connection 5 Clother (Specify) 21 Signature guitfrairal Service surface 22 Signature guitfrairal Service surface 23 Signature guitfrairal Service surface 24 Signature guitfrairal Service surface 25 Sequentially list conditions 15 Clother significant conditions of the disease of conditions of the surface of	(Specify	y only highest grade	completed)		(Give life. [kind of work done of OO NOT use retired	during most of wo	rking			
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20c. Haso of Disposition Name of 20c. Location - City or Town, Stete 1 20c. Death 20c. Location - City or Town, Stete 1 20c. Death 20c. Location - City or Town, Stete	EDITH S	MITH (GRAI	NDMOTHER)	10	ang	DIVISION	STREET	BATTIN	MODE M	21	217
A Condition S Other (Specify) MT. ZION CEMT. 1/30/ 2004 BALTIMORE, MD	20a. Method of Dispo	osition		20b. Place of	Dispo:	sition (Name of					
22. Name and Address of Facility WYLIE FUNERAL HOME PA 23. First, Enter the disease, if complications in all used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Onset and Death Constitutions and Death Constitutions and Death Constitutions. Sequentially list conditions. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 10 yes 20 ho 30 purpose of pregnancy in a past 12 months? 10 yes 20 ho 30 purpose of pregnancy in the past 12 months? 10 yes 20 ho 30 purpose of pregnancy in the past 12 months? 10 yes 20 ho 30 probably 4 purpose of pregnancy in the past 12 months? 24b. Was an again of probably 4 purpose of pregnancy in the past 12 months? 25b. Was case referred to medical examiner? 12 yes 20 ho 30 probably 4 purpose of pregnancy in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 12 yes 20 ho 30 probably 4 purpose of pregnancy in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 12 yes 20 ho 30 probably 4 purpose of pregnancy in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 12 yes 20 ho 30 probably 4 purpose of pregnancy in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 12 yes 20 ho 30 probably 4 purpose of pregnancy in the underlying cause given in Part I. 25c. Place of Death (Check only one) 25c. Was case referred to medical examiner? 12 yes 20 ho 10 posenthe how injury occurred underlying predictions of pregnancy in the past 10 posenthe how injury occurred underlying predictions of p			emoval from State	1 1			1	/ 2004	BALTIN	MORE.	MD
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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Final disease) (Conditions, if any, leading to immediate Cause) (Divested or Printy) (Inal indiated events resulting in death) (Last Due to (or as a consequence of): IF FEMALE:	231. Part1. Enter the	disease, r comp	cations that used	the death. Do no	ot ente					E,_MD	Approximate
Cause December of Prignary Cause Cau	Immediate Cause (F disease or condition resulting in death)	inal a	Narcot	ic Intoz		ntion					Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the conditions	Cause. Enter Under	nediate ying	Due to (or as	a consequence o	of):						
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examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCE 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Outpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCE 1 Natural 2 Novin; Day Year) 1 Yes 2 No Unknown 28. Place of Injury - At home, farm, street, factory, office 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCE 1 Injury - At home, farm, street, factory, office 1 Very - At home, farm, street, factory, office 28d. Describe how injury occurred Work? 1 Yes 2 No Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 6 Other (Specify) at SCE Unknown 28t. Location (Street and Nursing Home 5 Residence 10 Policient Nursing Home 5 Residence 10 Policient Nursing Home 10 Policient Nursing Home 10 Policient Nursing Home 10 Policient Nursing Ho								autop perfo	rmed?	prior to con death?	inpletion of cause of
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3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at Residence 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at Residence Baltimore, Waryland 28d. Location (Street and Wurghey or Rural Route Number City or Town, State) Baltimore, Waryland 29d. Date signed (Month, Day, Year)	27. Manner of Death	5 Pending investigation	28a. Date of Inju	ry 28b. Ti	ime of	28c. Injun Work	at	28d. Describe h	now injury occur		, ac beene
Found at Residence 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)			28e. Place of Injuding, etc			et, factory, office				9°Dï	Vision Str
(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)			Found at	Resider	nce			Baltimor	re, Mary	land	
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to will of the	29b. Signature and ti	itle of certifier	e A	2-	_		o number DCME				

State Registrar

31. Date filed (Month, Day, Year)

ZABILLEALT

32. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, Maryland 21201

			For State Registrer	State of Marylan	•		of Health a of Death		/giene	7 11 11 14	02022
			1. Decedent's Name (First, Middle, Las	7)	-			2. Date of D	eath Day	/ Year	3. Time of Death
	Physici /Medio		SR. M. ELIZABI	ETH AGNES PETR	OSKY,	MHSH		Janua	ο΄		6:05 A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	vn, or Location	of Death	4c.	County of Death	
			The Villa			Rod	gers Fo		Ва	ltimore	County
	Funeral		5. Social Security Number 6. Se	TM 267E		If Under 1 Y	ear If Under ays Hours	Min. 8. Date of B	irth ay, Year)		place (State or Foreign ntry)
	Director		220-54-5414 Usual Residence of Decedent	² 2 X 10	1 115.			Dec 24	, 19	02 Penr	nsylvania
	and		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation	<u> </u>			1	10d. Inside City Limits
	f sho	ō	1 1 D 1.1	0	D = J = .	For	~~				1 ☐ Yes 2 X No
	28a-	Director	Maryland Baltimo	re County	Rouge	ers For			10g. Cit	izen of What Cou	ntry?
	3a or		6806 Bellona Ave	nue			21212			USA	
	172 hours after death with the Maryland "neturel", or items 23a or 28a-1 show clical Exeminer must be notified at	Funerai	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Deceden	of Hispanic Or	igin? (Specify Yes or N n, Puerto Rican, etc.)	10-	14. Race - Amen	
ယ	after or ite	교	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No						Black, White,	
8	rei', e	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 22 Year or Dates:		1 ☐ Yes 2 🔀	No Specify:			Specify: W	hite
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2	Meni Meni Marke Marke	၉	William	Petros				izabeth	. 0'	. T Ot-t- 7	Farkopfsky
Maryland	d 2 should th and Mer 7 is marks traumatic	1	19a. Informant's Name/Relationship (7	(1.1.)	1			er or Rural Route Num			
	s 1 and f Health item 27 other t		Sr. Victoria Vand			W. JOI osition (Name		l, Towson,		Land ZIZ	
ō	Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	matory or othe	r place)				
Ë	tmen tent: tent:		`4 Donation 5 □ Other (Specify) Ne				y 1/29/200 ²			
Baltimore,	permit. Departminite importe any inju		21. Signatury Funcial Service (ib-	2Wyer	2	Name and A Mitchel	I-Wiede	feld Funer	al Ho	ome, Inc	• • • • •
	40 E 4 0		Martin D. Law 23a. Part1. Enter the disease, or comp	son				l, Baltimor		aryland	21212 Approximate Interval Between
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P.O. Box 68760,	death certificate e attending phy od for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	d	death 3	⊒Ectopic pregi □ Other (speci				23d. Date of deliv Month	ery Day Year
Records, F	signed d be de	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying caus	e given in Part I				he cause of death?
00	w requ	Completed						24a. Wa	s an	24b. Were auto	opsy findings available
Re	The lav	Ĕ						per	opsy formed?	prior to co	empletion of cause of
a	ien: Th rtificate	မ ငိ	25. Was case referred to medical				00 81		2 ☑ No	1 ∐ Yes	21 No
Vital		00	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	I ER/Outpatio	at 2 7 700	Other	e of Death <i>(Check only</i> ursing Home 5 Re		6 DOther (Sees)	6.0
ō	Physic this stal di	7. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?	28d. Describe			(9)
o	ding th. th. After funer	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	м	Work?	No			
Division	Attending or death. ector: After by the fune	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, st	reet, factory, o	fice			d Number or Run	al Route Number,
Ē	after Dire	erti	4 Homicide determined	building, etc. (Special	(y)			City or I	own, State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.							
	To the within 3	Mec	29b. Signature and title of certifier			29c. L	cense number		29d. Dat	e signed (Month,	Day, Year)
	⊢ 3 ⊢ ŏ			177000 has a			73186	<u></u>	11	27/04	
	2		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type		. , , , ,			17	
	0 `		Mein Kioune, M				wson M	arvland 21	20/1		
	Sta	ate	Of Date Clad (Marth Care Vaca)	22 Pagistraria Sign	nturo	74u, 10	waon, M	aryraid 41.	204		
	Regist		JAN 2 8 2	004 General	1 /9	Apr	achiel .	125			

Physic		1. Decedent's Name (First, Middle, La					2. Date of Death	Day Year	3. Time of Deat
/Medi		Virginia	L.	Py1es			Jan Jan	15 04	1:50 A
Exami		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Dee	
		Charlestown Care 5. Social Security Number 6. S		Marine land high de	Catonsv:			Baltimor	
Funeral Director			□ M 2 XF	(In yrs. last birthday, Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye October	Mar	thplace (State or For puntry) yland
3 - 25		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d Incide City I
Show	ō	MD Baltimo		Catonsvi					10d. Inside City Li 1 ☐ Yes 25
28a-	Funeral Director	10e. Street and Number		Oaconsvi	10f. Zip Code		100	Citizen of What Co	
38 0	0	711 Maiden Choi	co Lano		21228		103		
E E	ner	11. Marital Status	12, Was Decedent Ex Armed Forces?	ver in U.S. 13.	Was Decedent of Hi	ispanic Origin? (Specin, Mexican, Puerto P	rly Yes or No-	U. S. A	ncan Indian,
a B	y Fu	1 Never Married 2 Married	1 Yes 2 No)	1 ☐ Yes 2 ▼ No	Specify:	ican, etc.)	Black, Whit	
E E	d by	3 Widowed 4 Divorced	Year or Dates:				,		hite
na Pedici	lete	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	edent's Usual Occupa is kind of work done of DO NOT use retired	during most of workin	g 16t	o, Kind of Business	Industry (Industry
r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	Cle		,	F	ederal Go	vernment
od Menial Hygjene. marked other than "natural", or Hems 23a or 28a-f shov matic event, tra Medical Examinat must be notified at	0	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Mai	den Sumame)	
Mental arked o atic eve	To B	John Clifton Ge	ttier			Virgi	nia Ho	olzman	
E		19a. Informant's Name/Relationship (**	19b. Maili	ing Address (Street a	and Number or Rural			Zip Code) 210
em 27		Mr. John H. Ditto	, Jr.	Mr. J	onn H. Di	tto, Jr. 3	3716 Spri	ng Meadoi	Drive
° = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	Θ) Da	te 200	. Location - City or	Town, State
2 2 E		`4 Donation 5 Other (Specific	y)	Druid Rid	lge Cemete	ry 01/19	/04 Pil	kesville,	MD. 2120
Ueparm Importa eny inju		21. Signature of Funeral Service Licer	1500	2:	2. Name and Addres	is of FacilityLori	ng Byers	Funeral	Directors
	[()]		cllner Mo		28 Libert	y Road, R	andallsto	own,MD.21	
		23a. Part. Enter the disease, or com shock, or heart failure. List only	one cause on each line				respiratory arrest,		Approximate interval Betwee Onset and Deat
ysician Nedical		Immediate Cause (Final disease or condition resulting in death)	a		numou	ua			
aminer			Due to (or as a	consequence of):					
A _s	ĕ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
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ian ar urial-t		resulting in death) Last	Due to (or as a	consequence of):					
hysic the bi	lical		d						
ling pl	Med	IF FEMALE:	00-14					No.	
	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
attend for us	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□ Unknown	me of death 5L	Other (specify)				Ju) 1041
the attending p ched for use as f		De all Caberries (See as a see allaise	ontributing to death but	not resulting in the			23e. Did tobaco	o use contribute to	the cause of death
by the ached		Part II. Other significant conditions of	-71	resulting III (II0 ti	inderlying cause give	in in Part I.		41	obably 4 Unkn
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		•	For State Registrar		yland / De _l	partmer	nt of Health and Mate of Death	fental Hyg	giene Reg. No. 2		021	024
	Physicia /Medic		Decedent's Name (First, Middle, Last) SAMUEL		PE	RKAL		2. Date of Dea		.oó4°	3. Time of 9PM	Death M
	Examin		4a. Fecility Name (If not institution, give s 7121 PARK HEIGHTS	AVE # 206		4b. City BAL	, Town, or Location of Death TIMORE		4c. Coun	ity of Death		
	Funeral Director		220-03-0604	7. Age (In yrs, last birthda Yrs.	Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Dete of Bird (Month, De 07 17	1916	Coun	lece (State or try)	Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State MD 10b. County N/A	1	Oc. City, Town or BALTIMOR					1	0d. Inside Cit 1∭Yes	
3	3e or 28a	Il Director	10e. Street and Number 7121 PARK HEIGHTS	AVE #206		10f. Zi 212	p Code 15		10g. Citizen o USA	f What Cour	itry?	
020	72 hours after death with the Maryland naturel', or Items 23e or 28e-1 show dicel Exact or must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:	er in U.S.	3. Was Dece If Yes, spi	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 17 No Specify:	ecify Yes or No Rican, etc.)	В	ace - Americ lack, White, city: WHI	etc.	
7	within ene. then	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(G.	cedent's Usive kind of we. DO NOT		ing	16b. Kind of			
2	should be filed nd Mental Hygi i marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) UNOBTAINABLE		'		18. Mother's Nam	(UNK	(NWO			
	te ta		19a. Informant's Name/Relationship (Ty MRS. ROBERTA ATKIN		ER 1899	AQUA	ss (Street and Number or Rui		,MD. 2	1074		
<u>e</u>	of H		20a. Method of Disposition 1 Method of Disposition 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	BETTER OF DIS	MEDROS	offer place) 11/23/	P 2 004	ROSEDA	LE,MD.		
Balt	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licens	K	7,11		and Address of Facility SQI EISTERSTOWN	-		BRBS ₂₁ :	508.	
	Physician /Medical		23a. Pert1. Enter the dise se, or o mpi shock, or heart failure. List only o Immediate Cause (Fin disease or condition resulting in death)	a. meta	consequence of):	blu	de of dying, such as cardiac	or respiratory a	rrest,		Approximate Interval Bett Onset and I	ween
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):							
8760	ate be executed hysician and the burial-transit	ca	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending physocoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 Ectopic 5 Other (Date of delive Month		Year
ds, P.	requires that to been signed by should be deta	ρ	Part II. Other significant conditions co	ntributing to death but	not resulting in th	ne underlying	cause given in Part I.		obacco use co Yes 2 No			_
Division of Vital Records,	The law requate has been page 2 should	Completed						24a. Was auto perfo 1 Yes		b. Were auto prior to co death? 1 Yes	ppsy findings mpletion of c 2 \(\text{No} \)	available ause of
r Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatien	t 2□ER/Outpa	atient 3 🗆 [26. Place of Dea	th (Check only ome 5		Other (Speci	(y)	
o uoi	Attending Physician: r death. ector: After this certifics by the funeral director, p		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day			28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occ	curred		
Divis	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	, street, facto	ory, office	28f. Location (City or To		mber or Run	al Route Num	iber,
	se Hospi 124 hou 16 Funer Metely fill	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination and/o	leath occurre or investigation	ed at the time, date and place on, in my opinion, death occu	, and due to the rred at the time,	cause(s) and date and place	manner as s e, and due t	tated. o the cause(s	;)
)	To the within To the comp	Me	29b. Signature and title of certifier	· ~		2	9c. License number		29d. Date sig	ned (Month,	Day, Year)	
	3		30. Name and address of person who co Robert M. Coope		ath (Item 23a) (Ty くいろ のみ	/pe, Print)	HEIGHTS A	15 B1	out m	0 212	-15	
ė,	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar		/						

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	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year 2004	3. Time of Death
	4a. Facility Name (If not institution, give						4c. Cour	ty of Deeth	O HOLIM
	5. Social Security Number 6. Sex 217-12-7986	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb.	N / th y, Year) 1 1 9 2	9. Birthp	lace (State or Foreign htry) Cyland
Aaryland I show	10a. State 10b. County							1	0d. Inside City Limits 1 ☐ Yes 2√2 No
with the has or 28a- the notifical	10e. Street and Number		пате	10f. Zip Code	227		10g. Citizen o		
It, or Items 23	11. Marital Status 1 ☐ Never Married 2 🌠 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Pican, etc.)	В	d Sta ace - Americ lack, White, wify: Whi	ean Indian, etc.
within 72 hou sne. then nature is Madical E	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed)	(Give life. I	kind of work done of DO NOT use retired	during most of work ()	king	16b. Kind of		
tal Hygi d other event, Be Cc	17. Father's Name (First, Middle, Last)		ASSEI	IDIY WOL	18. Mother's Nam Edna M		Maiden Sum		.CS
ulth ar 27 is r trau									Code) 21227
Pages 1 at the tank of He tank: If item jury or oth	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State Ba	lace of Dispo emetery, crer yview	sition (Name of natory or other plac Cremato	ory 1-26	Date	20c. Location	- City or To	
Departition Depart	21. Signature of Funeral Service License	90	22	Name and Address	ss of Facility Hu	bbard	Funer	al Ho	me, Inc.
/Medical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	OVOS (Å	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
sician and burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence:	uence of):	ren.					years
death certifica e attending ph d for use as th	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3					Date of delive	ery Day Year
be of pe	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	- 1	ntribute to th	ne cause of death?
The law require cate has been single 2 should Completed						24a. Was autor perfo	an 24th	b. Were auto prior to cor death? 1 ☐ Yes	psy findings available inpletion of cause of
hysician this certifu al director.	TO THE ZENNO		ER/Outpatien		4 Indising in	ome 5 Resi	one) dence 6 🗆 C		y)
Attending ir death. ector: After by the fune ification	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifi	28b. Time of Injury	M 1 🗆	yat ⟨? Yes 2 □ No	28d. Describe	Street and Nur		l Route Number,
Hospita 4 hours Funeral iely filled ical C	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, death	n occurred at the time	ne, date and place, pinion, death occur	and due to the	cause(s) and r	nanner as st	ated. the cause(s)
To the complet	29b. Signature and title of certifier	langay M	0	29c. License	7595		29d. Date sign		Day, Year) -5, 2084
3	30. Name and address of person who co		23a) (Type,	Print) Aanes	HEALTH				
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Space					

		•	1 - State Registrar	State of Maryland		artment of H rtificate of I		d Mental Hy	/gien Reg. N	ZUI) 4	020	126
	Dhuaisia		1. Decedent's Name (First, Middle, Last)					2. Date of D Month		^{ay} 23	^Y °°04	3. Time	
	Physicia /Medic		Willis D. Rile									3:15	Ам
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		eath		c. County			
	Funeval		Hospice of the 5. Social Security Number 6. Sec		st birthday)	linthic If Under 1 Year	If Under 24 I	rs. 8. Date of B	irth .	nne	Aruni 9. Birthp	ace (State	or Foreign
	Funeral Director		232-38 - 7061 1×	IM 2□F 73	Yrs.	Months Days	Hours N	fin. 8. Date of B (Month, D AUGUST	ay, Year	193¢	Coun	(V) Vir	ginia
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Lo	position					1	Od. Inside	Titu Limite
	Aaryla I shov	ŏ									1		s 2 X No
	28a-1	Director	Maryland Anne Ar	under Pas	adena	10f. Zip Code			10g. C	itizen of V	Vhat Cour	try?	
	h with		8482 Byrd Road			21122)			USA			
	deat	Funeral		12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin?	(Specify Yes or N	0-	14. Race		an Indian,	
ဓ္က	or It	by Fu	1 Never Married 2 Married	1 XiYes 2 □ No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify		ite	
Ö	within 72 hours after death with the Maryland ene. Than "neturel", or flems 23a or 28a-1 show ta Madral Examiner anal bamailled at	ed b	3 Widowed 4 Divorced	Year or Dates:	16a Decer	dent's Usual Occupa	ation		16b F	Cind of Bu	siness/Inc	fustn/	
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22	d with giene ar tha	mo.	12	College (1-4or 5+)	Gener	al Forema	ın			Chem	ical	Comp	any
2	be illed within 72 hours after death with the Marylan at Hygiene. All Hygiene. All Hygiene. All Hygiene. Avent, It a Macilcal Examiner must be notified at event, it a Macilcal Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)	D:1				Name (First, Middle		n Sumam	_		
yla	should be and Mental s marked c	٩	Willis D	Ril			Mary	Gra			`	/ne	
Mai	s 1 and 2 should f Health and Men flem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Diane C. Riley	spouse		ng Address (Street a					State, Zip	Code)	
ē,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tra once.		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of	1	Date			City or To	wn, State	
ē.	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Ponation 5 ☐ Other (Specify)	emoval from State	4114	matory or other place ematory II		6/04	Bal-	timor	re Ma	rylan	d
Baltimore, Maryland 21215-0036	permit. Departm Importer any inju		21. Signature of Funeral Service License			2. Name and Addres	6 Facility	Stallings					
<u> </u>	8 8 1 2 8		by 2.	XX 1	3	111 Mount	ain Ro	ad Pasade	na.			- I •Λ	•
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the death.			g, such as care	diac or respiratory	arrest,			Approximation of the Approxima	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Liver -	fai	luce						4 W	eks
	/Medical Examiner		rosolung in south)	Due to (or as a conseque	1960 of): Ollul	1 1 (ara	noma	_		.	21 n	nonth
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque		are -	-(70,	770 7770					1077
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8760 20	cate be executed physician and the burial-transit	dicai		1									
9 ×	eath certific attending p	/Mec	IF FEMALE:	3c. If yes, outcome of pregnand	~v					004 0.4	(- (- (- (- (- (- (- (- (-		
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	leath 3[Ectopic pregnancy Other (specify)				Mor	e of delive nth	Day	Year
o.	that the de	Physician/Me	1	9□ Unknown									
o,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions cor	ntributing to death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contr	ibute to th	e cause of	death?
ord	w require been sig should b	ted						- 10	Yes 2	X 100	3 Prob	ably 4]Unknown
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 7:00 A M **Physician** JANUARY GRACE GRAY ROBERSON 28, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHESAPEAKE HOSPICE HOUSE ARUNDEL LINTHICUM ANNE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 20K F 578-52-6553 MAY 13, 1939 Director 64 WASHINGTON DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner result be notified at 1 Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 8177 KRAMER COURT 21061 death v 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be tiled within 72 hours after. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Examina 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12 SECRETARY Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) Be EDNA GRAY ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LISA JACKSON - DAUGHTER 204 MILLERSTONE WAY MILLERSVILLE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) JANAURY 29 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatign 5 ☐ Other (Specify) 2004 CATONSVILLE, MARYLAND METRO CREMATORY ` 4 □ Donatigri 21. Signature of Funeral Service Licensee KIRKLEY ARUDDICKY FUNERAL HOME P.A. 21061 au 421 CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician tastati i 3 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be exical Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Other (Specify) 2 No P 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After the Hospitel or Attending 1 Natural 2 Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral I filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed suse of death (Item 23a) (Type, Print) 30. Name and address of person fory sente IUD 1028 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 8 2004 Registrar

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

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JANUARY

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			1 - For State Registrar	State of Ma	aryıan		epartment of F Certificate of			giene leg. No. 2 (004 02029
	Physici		1. Decedent's Name (First, Middle, Las John Samue1 Reve11						2. Date of Dea Month	Day	Year 43 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		١ .	4b. City, Town, o	or Location of Death	- U-1 1 000	4c. County	of Deeth
			Maryland Gen	eral Hi	250	ital	Daltir	nove 1	YTU	N/A	
	Funeral		5. Social Security Number 6. Se 705–12–5516	x 7. Ag XM 2□ F	e (In)rs. 86	last birthd Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (Stete or Foreign Country)
	Director		Usual Residence of Decedent			113			October	24,191	Maryland
	aryland show		10a. State 10b. County		10c. City	y, Town o	r Location				10d. Inside City Limits
	the Mar 28a-f st	ctor	Maryland Baltimor	e		Balti	imore				1 ☐ Yes 2 No
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show he Medical Evantimer must be molified at	by Funeral Director	10e. Street and Number 708 Regester Ave.				10f. Zip Code 21212			Og. Citizen of N United	
	items items	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S.	13. Was Decedent of H If Yes, specify Cuba	dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.
98	s afte	y F.	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give	No		1 ☐ Yes 2 🗓 No	Specify:		Specify	
78	72 hour natural	ed b	15. Decedent's Ed	Year or Dates:	WW I		ecedent's Usual Occup	nation		16h Kind of B	usiness/Industry
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P	be filed ital Hygi od other event, L	3e C	17. Father's Name (First, Middle, Last)					18. Mother's Name			ne)
yla	should be nd Mental marked o	2	George W. Revelle			_		F1orence			
Marylan	and and sum		19a. Informant's Name/Relationship (7	•		1	ailing Address (Street				
~ °	s 1 and 2 f Health item 27 other tra	2	Emma B. Revelle/wi	TT6	20b. P		Eutaw Pla		imore,		CL / City or Town, State
No.	Pages nent of I int: if it		1 XBurial 2 ☐ Cremation 3 ☐				sposition (Name of crematory or other place	1			
Baltin		1	'4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service License		Gre	enmo	unt Cemete 22. Name and Addre	ss of Facility	27,2004		nore, Maryland
œ e	permit. Departimports eny inj		Defu D. Mitch	IN THE		1	Mitche	e11-Wiedef more, MD	eld Fun 21212	eral Ho	ome, Inc. York Rd.
			23a. Port1. Enter the disease, or composition, or heart failure. List only of	lications that caused	the death	n. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Proc	tat	-0	Cance				Onset and Death
	/Medical Examiner	ğ –	resulting in death)	Due to (or as	a consequ	uence of):	3	1.			
	Lammer	_	Sequentially list conditions,	b. Due to (or as	ari	dic	11 10	archi	00		
EXI	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence or).					
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760		70	(d							
Box 687	leath certificate attending phys I for use as the	Aedi	IF FEMALE:								
Š	ith ce tendii	an/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	of pregna	incy I death	3 Ectopic pregnancy	/		23d. Dat	te of delivery nth Day Year
O.	ne des the al	Physician/Medic	1 Yes 2 No	4□Pregnant at 9□Unknown	time of de	eath	5 Other (specify)		-	1010	nui Day 16ai
P.O.	res that the de signed by the a l be detached t	Ph)	Part II. Other significant conditions co	ontributing to death b	ut not resi	ulting in th	e underlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to the cause of death?
ģ.	uires I sign	d by		-			_, ,		1 🗀 Y	es 2 🗆 No	3 Probably 4 Unknown
100	w require been si should l	Completed							24a. Was a	n 24b. \	Were autopsy findings available prior to completion of cause of
Re	The lav	dwo							autops perfori 1 Yes	med?//	orior to completion of cause of death? I □ Yes 2 □ No
ital	ician: Th certificate ector, pag	BeC	25. Was case referred to medical					26. Place of Death			165 20140
>	Physician: this certific al director,	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 [Inpatie	ent 2 🗆	ER/Outpa	tient 3 DOA Oth	er: 4 Nursing Hor	me 5□Reside	ence 6 Oth	er (Specify)
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Yea <i>r</i>)	28b. Tim Inju	ry Wor		28d. Describe ho	ow injury occurr	red
isio	Attendideath ctor: A the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		un. At ho	mo form	M 1 [Yes 2 □ No	29f Location /Fi	root and Numb	er or Rural Route Number,
Div	or A	Certification:	4 Homicide determined	building, et	c. (Specif)	y)	, street, factory, office		City or Town	n, State)	er or Aufar Adule Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Cartifying Phy (Check only one)	sician: To the best iner: On the basis o and manner st	examina examina	wledge, d tion and/o	eath occurred at the tin r investigation, in my o	me, date and place, a pinion, death occurr	and due to the co ed at the time, d	ause(s) and ma ate and place, a	nner as stated. and due to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date signed	(Month, Day, Year)
	7		P. Chahb	(89	1492		12	3/04
	14	3	30. Name and address of person who	completed cause of d	leath (Item	23a) (Ty	pe, Print)	10d G	0.00.00	I H:	In Line
100	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	14100 110	WIU OC	MALL	1 116	white.
	Registr		IAN 2 8 2004	Be week	- Elect	La	4	>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month K DEL JAN 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ELIZABETH'S REHAB & NURSING BALTIMORE
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 220-05-8896 84 Director AUG.4,1919 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examitist 1: and be notified at 1X Yes 2 □ No Completed by Funeral Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 155 S. GRUNDY STREET 21224 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 🎾No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 MEAT DEPT GROCERY STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN RYAN ဥ DELIA WOODS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 HUDSON STREET, BALTIMORE, MARYLAND 21224 RITA KOUBEK/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) permit. Page Department of Important: If any njury or once. NEW CATHEDRAL CEM! 1/30/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LILLY & ZEILER LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nanition DW Wells /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oriunun your Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 ☐ Other (specify) 4 Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 Yes 2 💢 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification; To 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. injury at Work? the Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)2754 Kaka MD

Registrar
DHMH 17 Rev 1/2001

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altimore

30. Name and address of person who completed cause of death (IJem 23a) (Type, Print) GETHE RAJA MD 4367 Holling few

32. Registrar's Signature

31. Date filed (Month, Day, Year)

8 2004

		·	1 - State Amend Item#8	State of Mar per fh G82	yland / [28 2/20	Departme Certifica	nt of Heal	Ith and Nath	Mental Hy	giene Reg. No.	200	+ 02031
, /	hysicia /Medic xamin	al er	Decedent's Name (First, Middle, Lass SARAH Aa. Fecility Name (If not institution, give	STO	OKES	4b. Ci	ty, Town, or Loca	ation of Death	2. Date of De Month Januar	Day 26	Year 2004 County of Dea	
	neral ector		Johns Hookins Boy 5. Social Security Number 6. Sc 217-34-7345 Usual Residence of Decedent		'In yrs. last bir			Inder 24 Hrs. Durs Min.	8. Date of Bir (Month, Da	th 1/8	N/ /1939 Bir 3- Mai	A thplace (State or Foreign ountry) ryland
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1275-0036 within 72 hours after death with the Maryland with the Maryland ene.	Exe.	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			cedent of Hispan pecify Cuban, Me 2 X No Sp	nic Origin? (Specifican, Puerto pecify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whi Specify: B	te, etc.
Z 1 Z 1 5-0036 d within 72 hours afi giene.	the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 11th	ucation de completed) College (1-4or 5+)		Decedent's U (Give kind of life. DO NOT	sual Occupation work done during use retired) Assis		king	She	nd of Business pard I ospita	Pratt
Viand	event,	To Be C	17. Father's Name (First, Middle, Last)				Li	lliar	ne (First, Middle n Ander	son		
C = 1	other treumatic		19a. Informant's Name/Relationship (7 Shirley A. Dors			-	oss (Street and N					Zip Code)
Baltimore, permit. Pages 1 at Department of Hea			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemete	f Disposition (A ry, crematory of Crema	r other place)	1	Date 2004		cation - City or	
Balti permit. Departr	eny injury o		21. Signature of Funeral Service Licen	Witter			and Address of	FAC	tter F	une	ral Ho	ome Inc. D. 21216
	ician dical niner		23a. Part1. Enter the disease, or complete shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. ACIDE Due to (or as a	MIA consequence ISCHE	of): =M/A	ode of dying, su	ch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
0	ysician and ne burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a constant of the constant of th	LIC A	RREST)PD					
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To th	сотр	Me	29b. Signature and title of certifier	4	MI		29c. License nur			29d. Date	signed (Mon	th, Day, Year)
,	2		30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print)	e, Balti		MD 21	224	3 (
	Sta Registr		FLORA KISUULE, N 31. Date filed (Month, Day, Year)	32. Registrar		L	1	/	ent.	1		

DHMH 17 Rev 1/2001

ORIGINAL

	1	- State RegistrarAMEND ITEM #18	PER FH G827	1/28/04 D e	rtificate	e of L	Death			Reg. No.	2004	0203
Physician		. Decedent's Name (First, Middle, Last) JAYVEE E.	SANTOS						2. Date of De Month	Day		3. Time of Death
/Medical Examiner	4	a. Facility Name (If not institution, give substitution of MARY	treet and number)			Town, or	Location o	of Death	Januar		County of Dea	4
Funeral Director		-17 0 - 33,2	7. Age (1) 7. Age (1) 21	In yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct.18	th ly, Year) 1981	- C	thplace (State or Fore ountry) illipines
fied at	1		1	Oc. City, Town or Li						·		10d. Inside City Lim
or Items 23e or 28e-1 e programme the noutiled Funeral Director	1	0e. Street and Number 814 Washburn Ave	•		10f. Zip	Code 21225	5			-	en of What C	ountry?
- A	7	Marital Status Never Married 2 Married Widowed 4 □ Divorced	I2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:	er in U.S. 13.	Was Deced If Yes, spec		ispanic Origin, Mexican	gin? (Sp , Puerto	ecrify Yes or No Rican, etc.)		4. Race - Am Black, Whi Specify: Wh	
n ariu mental mygene. 7 is marked other than "naturi fraumatic svent, the Medical E		15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usua kind of wor DO NOT us	rk done d se retired	turina most	t of work	ing	16b. Kin	n/a	/Industry
ent, t	1	7. Father's Name (First, Middle, Last)	U		daciic		18. Mothe	r's Name	(First, Middle,	Maiden S		
arked oth attic sven		Gregorio	Santos Jr				Ec	len		Euite	= EDEN	EQUITA
ls ma		19a. Informant's Name/Relationship (Type	•						al Route Number			Zip Code)
em 27 em 27 ethar tr	_	Gregorio Santos J	`	Addition of the Control			Ave.		timore,			
or it	2	0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		20b. Place of Dispo cemetery, cre	matory or or	ther place			Date	20c. Loc	ation - City or	Town, State
Important: Important: Important: Once.	7	*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License	24)	Cedar H	2. Name an	d Addres	s of Facilit	y	5/2004 ik F u nei		timore	•
15 5 9	S.	23a. Part1. Enter the disease, or compli	Jann	110	23	7 E.	Pata	DSC	Ave. 1	Balti	more,	Md. 21225 Approximate
shysician and the burial-transit abundance Examiner	r	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying cause (Disease or injury hat initiated events esulting in death) Last	Due to (or as a c	инэвциейсе ий.								
ed by the attending physicial detached for use as the but the	- 1	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pre					2:	3d. Date of de Month	ivery Day Year
		art II. Other significant conditions con Ediopathic de		covoling in the u				_				the cause of death
ate has page 2							/		24a. Was autop perfo 1 🗆 Yes	med?		utopsy findings availa completion of cause 2 No
director,	1	!5. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpatier		Othe	ar:	123125-	Check onl o			
stor: After this or the funeral direction: To		7. Manner of Death 1. ■Natural 5 □ Pending 2. □ Accident investigation	28a. Date of Injury (Month, Day Y			Bc. Injury Work			ne 5 ☐ Resid 28d. Describe h			cify)
rtif		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, sti Specify)	reet, factory	, office			28f. Location (5 City or Tox	Street and m, State)	Number or Ru	urai Route Number,
To the Funeral L completely fitled i	1	(Check only 2 Medical Examir one)	ician: To the best of n er: On the basis of ex and manner stated	amination and/or in	vestigation,	in my op	pinion, deat	d place, a	and due to the o ed at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
5	2	19b. Signature and title of certifie	Kilm 11	n D	29c.	License		2			signed (Mont	/
0		John Comment	- , - ,,	W > .		Y	1463	2	, MD		23/0	7

	ı	1 - For State Registrar	State		nd / Depa	artmen		ealth and I	Mental Hy		004	02033
Physicia	20	1. Decedent's Name (First, Middle							2. Date of Dea	ath Day	Yeer	3. Time of Death
/Medic			eider						January		2004	9:30 P. ^M .
Examin	er	4e. Facility Name (If not institution,	give street and n	umber)		4b. City,	Town, or L	ocation of Deatl	1		nty of Death	
		7080 Cradlerocl 5. Social Security Number	c Way #41 6. Sex	7. Age (In yrs.	last hirthday)	If Under	Colun	nbia If Under 24 Hrs.	8 Date of Birt		oward	place (State or Foreign
Funeral Director		215-07-7391	1 M 2 SkF	88	Yrs.	Months		Hours Min.	8. Date of Birt (Month, De)	7, Ye <i>er)</i>		plece (State or Foreign htry) MD
		Usual Residence of Decedent							103/01/			rii)
nylan how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
e Ma	cto	MD Howard	d		Co1	umbia	l					1 ☐ Yes 2 🗷 No
ith or 2	Dire	10e. Street and Number				10f. Zip	Code			10g. Citizen	of What Cour	ntry?
ath v	by Funeral Director	7080 Cradleroc		416 cedent Ever in U	10 10	Was Dass	2104		nacifu Vac as Na		USA Rece - Americ	nan Indian
ter de litem	-un	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed I		7.5.	If Yes, spec	city Cuban,	, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	Black, White,	
036 urs af		3 ⊠ Widowed 4 □ Divorced	If Yes, C Year or	evice		1 🗆 Yes	2 % No	Specify:		Spe	cify:	hite
1215-0036 within 72 hours after death with the Maryland ene. Print "Patural", or itema 23e or 28e-f show then "Patural", or itema 23e or 28e-f show the death of the continent o	Completed	15. Decedent (Specify only highes	's Education	()	16a. Dece	dent's Usua	al Occupati	ion iring most of wor	kina	16b. Kind o	f Business/In	
Per ithin 7	nple	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT u	se retired)	ining most or wor	Amig			
led w her th		12			Hom	emake		IO. Matheda Nas	(Fire Middle	Maidae Cua	Own H	ome
and lbe fi	Be	17. Father's Name (First, Middle, I		•			1		ne (First, Middle,		iame)	
Maryland 21215-0036 d 2 should be filed within 72 hours att in and Mantal Hyghen and in a firm arked other than "natural; or traumatic event, the Manical Event traumatic event	2	Wade Hampton St		<u>d</u>	19b Maili	na Address	(Street an		irgaret (Iral Route Numbe		wn State Zin	Codel
Ma d 2 s lith an traul		Norman W. Schn		/Son					Columb			,
Heal Heal other		20a. Method of Disposition	eruer , or	20b. F	Place of Dispo	sition (Ner	me of	1	Date		on - City or To	
Dages ent of nt: If i		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (St		n State		•		em. 01/2	4/2004	Balti	more,	MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the marked other than "natural; or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Exercitive must be notified at once.		21. Signature of Funeral Service I		Jul					wab Fune			
Bal permi Depa Impo eny ii		Adre &	Julias	_					Baltimo			
***	3	23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the deal	th. Do not en	ter the mod	de of dying,	such as cardiad	or respiratory ar	rest.		Approximate Interval Between
Physician	î	Immediate Cause (Final disease or condition	Me	KASTATT	CB	owel	CA	ncon				Onset and Death
/Medical Examiner		resulting in death)	Due to	o (or as a consec								tric y
Examiner	L	Sequentially list conditions,	b	o (or as a consec								
ped last	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	K Dag (o (or as a consec	querice or).							
60, be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c	o (or as a consec	quence of):							
760, te be executed ysician and te burial-transit												
68 ifica ifica ss th	by Physician/Medical		u							1		
Box sath cert attending for use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c	utcome of pregn		∃Ectopic pi				23d.	Date of delive	ery
death	slcla	in the past 12 months? 1 □ Yes 2 No		gnant at time of d		Other (sp					Month	Day Year
P.O.	hys	9 ☐ Unknown										
S, L	by	Part II. Other significant condition	4	death but not res	sulting in the u	nderlying o	ause given	in Part I.				ne cause of death?
ord equir	ted	- Hypente	ww						1 1 1	es 2 LJ No	3 ☐ Prob	ably 4 Unknown
lecolar law law las by a 2 st	Completed								24a. Was autop	sv	prior to cor	psy findings available inpletion of cause of
The cate I page	Cor								1 Tes	med? 20 No	death?	2 No
Vita ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Othor		th (Check only o			
Of Phys	<u>2</u>	1 Yes WNo 27. Manner of Death	1	Inpatient 2	ER/Outpatier		JA	4 Nursing H	ome 5 Aresid			y)
On ding th. After	tlon	1 Natural 5 Pending 2 Accident investig	9	e of Injury onth, Day Yeer)	Injury	М	28c. Injury a Work? 1 ☐ Ye	es 2 🗆 No		,,		
Division of Vital Records, for Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	fica	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Pla	ce of Injury - At h	iome, larm, st	reet, lactory	y, office				mber or Rura	l Route Number,
Div al or s afte ii Dire	Certification;	4 Homicide	DUI	lding, etc." (Speci	'y)				City or Tow	n, State)		
Division To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the		29a. Certifier 1 Cartifyin	g Physician: To t	he best of my kno	owledge, deat	h occurred	at the time	, date and place	, and due to the	ause(s) and	manner as st	ated.
he Hi he Fu	Medical	one)	xaminar: On the and ma	nner stated.	ation and/or in	vestigation	i, in my opir	nion, death occu				
To t To t	Σ	29b. Signature and title of certifier					c. License r				ned (Month,	Dey, Year)
/		premu	2			1)	-34	186P		IAN	20,0	204
Ŋ		30. Name and address of person	who completed ca	use of death (Ite		Print)	2 -	- A	C Colin	6	14	21,0
0.		31. Date liled (Month, Day, Year)	22	Registrar's Sign	L (+	ru /	my	Lew Il	- Oliv	ions	mis	0044
Sta Registr		JAN 2.8		Del. 20 0	12 1	A SALVEN						

			. For	State of M							-		_			
		•	1 - State Registrar			Cei	rtificate	e of D	eath			Reg. No.	200		020	34
			1. Decedent's Name (First, Middle, Las	it)							2. Date of D	eath Day	/ Ye		3. Time of Deat	
	Physicia /Medic		Frank Neal Sible	2y							Jan.	26			1:25 p.	. M
	Examin		4a. Fecility Name (If not institution, give)		4b. City, 1	Town, or L	ocation o	of Death		4c.	County of D			
			Greater Baltimore					vson					Balti			
H	Funeral		5. Social Security Number 6. S	9x 7. Ag ☑ M 2☐ F		last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	B. Date of B. (Month, C. June)	irth (ay, Year)	9.	County	e (State or For	eign
	Director		216-44-3284 Usual Residence of Decedent	X	88	113.					June .	J, 191	J M	aryI	and	
and	6 mm		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d	Inside City Lin	nits
Mary	49	ţ	Maryland Baltimor	ρ	Co	ckeysv	rille								1 ☐ Yes 2 ☐	No
the	128e	Funeral Director	10e. Street and Number			ORC). SV	10f. Zip	Code				10g. Cit	izen of Wha	Country	17	
h with	23a o	O I	13801 York Rd.				21	030				U	.S.A.			
deat	er in	ner	11. Marital Status	12. Was Decedent Armed Forces	7	S. 13.	Was Deced	ent of Hisp	panic Ori Mexicar	gin? (Sp	ecify Yes or N Rican, etc.)		14. Race - A Black, V			
affe o	or It	교	1 ☐ Never Married 2 ☐ Married	1 XYes 2 ☐ If Yes, Give Year or Dates:	No		1 ☐ Yes 2		Specify:				Specify:	Whi		
5-UU30	ural,	d by	3 Widowed 4 Divorced		WW TT							100 100				
G Z I Z I 3-0030	asites	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usua kind of wor DO NOT us	k done du e retired)	ring mos	t of work	ing	10D. K	ind of Busine	ess/indu	stry	
N idiw	than than	m.	Elementary/Secondary (0-12)	College (1-4or	5+)		ancial				dent	U.S	S. Pos	tal	Service	3
	ial Hygiene. Id other than "natural", or liems 23a or 28e-f show event, the Medical Examitme must be notified at		17. Father's Name (First, Middle, Last)								e (First, Middi	e, Maiden	Surname)			
yland yland	ked c	To Be	Neal	Sibley					Haz	el		Sch	nobel			
_ ~	Health and Mental Item 27 is marked other traumetic ev	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street an	d Numbe	er or Rur	al Route Num	ber, City o	r Town, Stat	e, Zip C	ode)	
Man and and and and and and and and and a	127		Arlene Sibley (da	ughter)		2236	Arbo	r Lar	ne Sa	alt 1	Lake Ci	ty,	Utah 8	3411	7	
<u> </u>	of Head f Item r othe		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □	Domoval from State		lace of Dispo emetery, crea	osition (Narr matory or ot	ne of ther place))		Date	20c. Lo	cation - City	or Tow	n, Stete	
Baitimor	Department of Importent: If I any injury or once.		*4 □ Donation 5 □ Other (Specify	y)	Gre	eenmou									yland	
	Departimont any injured once.		21. Signature of Funeral Service Licer	ISOO N		22	2. Name and Mitch	d Address	of Facility	y lefe1	d F.H. Baltin	Tnc				
n 8	10 = 2		1 Callert m	Trust	_		650	00 Y	ork	Rd.	Baltin	ore,	Maryla	nd ?	21212	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the deat line.	h. Do not en	ter the mode	e of dying,	such as	cardiac	or respiratory	arrest,		l lr	pproximate nterval Between Inset and Death	
	nysician		Immediate Cause (Final disease or condition	a	.0	₩ L J M (uence of):	AIMO							1	4 das	
	/Medical xaminer		resulting in death)	Due to (or a	s a cons	uence of):			110							
		<u></u>	Sequentially list conditions,	b. Due to for a	U POOMS	Pance of:	ESIA	AL	176	1021	HAGE				Jays.	
) <u>1</u>	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(11/6	65111	1	1400	15	FALL	WAGE			ر ا	7861	(
	n and al-tra	Xai	that initiated events resulting in death) Last	C. Due to (or a	s a conseq	uence of):		01,001	10	1 1/10	111-0			-	7607	
		le ca		d												
. BOX 687	g phy as th	Physician/Medi														
XON TO	endin use	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			⊒Ectopic pre	egnancy					23d. Date of			
J. 19	0 7	sick	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (sp						Month	U	ay Year	
J. B	t by the etached	Phy	9 Unknown		h				in Dani		220 Die	Itabaaaa	una anntribui	o to the	cause of death	2
ecords, P.O	igned be det	þ	Part II. Other significant conditions of	contributing to death	Dut not res	ulting in the t	иоепунд с	ause given	ımranı	•		Yes 2	_	Probab		
ecords,	been si	Completed														
Sec .	has b	holdu									24a. Ws	is an opsy formed?		to comp	y findings availabletion of cause	
a K											1 Yes	2 \ √ No		Yes 2	□ No	
Vital	certificate	Be	25. Was case referred to medical examiner?	Hospital:		- TI-		Other			h (Check only					-
ö	rthis raid	٠ <u>۲</u>	1 Yes 2 No	28a. Date of In		ER/Outpaties 28b, Time o		8c. Injury a Work?	4 🗆 N	ursing Ho	ome 5 Re 28d. Describe			specify)		
Division of	h. After funera	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, D	ay Year)	Injury	м		os 2□	No						
/ISI	r death actor: A	Certification:	3 ☐ Suicide 6 ☐ Could not b	286. Place of II			reet, factory	, office			28f. Location	(Street en	d Number o	r Rural F	Route Number,	
á	afte of in t	ert	4 Homicide	building, e	etc. (Sp e cil	у)					City of 1	own, state	,			
9	hours unere ly fille			nysicien: To the bes												
Division of Vita	within 24 hours after death. To the Funerel Director: 4 completely filled in by the fu	Medical	one)	miner: On the basis and manner s		LIGHT AND OF IT				aut OCCUI	ou at the time					
Ä	To t	Σ	29b. Signature and title of certifier	1 1			290	. License	number			29d. Da	te signed (M	ionth, De	y, Year)	
			7 9	H	1	2		150	23	5			1/27/	4		
	10		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type,	Print)	Λ		111-	!		44.6		2 0	
	10		31. Date filed (Month, Day, Year)	32 Radie	trar's Signa	XO L Y	DRU	50	(00	ue.	75011	12	MO	40	50	
	Sta Regist	ate	IANI 9 0 200 A	la Da	مر ما	L	A.		8							

TE STU	KDT.	1- For Amend Item#29d,p	State of Ma erME, G827,	aryland / De 1/28/2004	epartment of Effificate of	Health and I Death	Mental Hygien	e 2004	02035
		1. Decedent's Name (First, Middle, Las)				2. Date of Death Month D	ay Year	3. Time of Death
Physi /Mei	ıcıan dical	Dodgie		Stur	divant			2004	5:55 A ^M
Exan		4a. Facility Name (If not institution, give				or Location of Death	1 4	c. County of Death	
		2121 WINDSOR GAR				MORE CITY		NA	
Funera Directo		213-34-4900	XIM 2□F	(In yrs. last birthe	Months Davs		8. Date of Birth (Month, Day, Yea 9–22–38	r) Cou	place (State or Foreign ntry)
pu *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	or Location				10d. Inside City Limits
anyla eho	5		,						Yos 2 □ No
the N	Director	MC. NA		Dail	imore		100.0	Citizen of What Cou	ntry?
with	<u> </u>	2121 Window Con		225	2120				,.
death with the Maryland ms 23a or 28a-f ehow	era	2121 Windsor Gard	12. Was Decedent I		13. Was Decedent of If Yes, specify Cu			USA 14. Race - Ameri	
ja 22 22	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	10			o Rican, etc.)	Black, White,	etc.
urs a	۵	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2XX No	Specify:		Specify: Bl	.ack
Y 12.13-0050 Within 72 hours after death with the Marylan jiene. Than 'naturat', or items 23a or 28a-f ehow the Modical Examines must be notified at	ted	15. Decedent's Ed	ucation	16a. D	ecedent's Usual Occu	upation	king 16b.	Kind of Business/Ir	ndustry
d within 72 hours affigiene. The Medical Exami	age	Elementary/Secondary (0-12)	College (1-4or 5	+)	Give kind of work don- fe. DO NOT use retir			_	
9 5 9 -	Completed	12th grade		Tr	actor Tra			nyder	
yidild a buld be filed Mental Hyg arked othe	a e	17. Father's Name (First, Middle, Last)		Sturdiva	nt Cr	18. Mother's Nam	ne (First, Middle, Maide	_	
2 should be and Mental is marked (saumatic ev	ျ		0:			1		Lawson	0.71
Good Mark yield to the stand of the stand of the stand were the stand were or other traumatic		19a. Informant's Name/Relationship (7) Angela Jones	Daughter				ral Route Number, City Newark, N.		
1 and 2 Health tem 27 is		20a. Method of Disposition	Daugittel	20b. Place of D	isposition (Name of			Location - City or T	
Pages 1 au nent of Hea int: If item iry or other		1 Burial 2 ☐ Cremation 3 ☐		cemetery,	crematory or other pl n Forest \	l l	11, 233	ings Mill	
mit. Pag partmen portant: y injury		* 4 Donation 5 Other (Specify 21. Signature of Funeral Service-License		Galliso	22. Name and Add				
permit. Pages Department of Important: If I	S I I	21. Signature of runoral Service Literal	2		March F.			ore, Md. North Ave	21202
B9-37-3		23a. art1. Enter the disease, or comp	cations that caused	the death. Do not				NOLCII AVE	Approximate Interval Between
ate be expound hysicien and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)					
certificate nding phys									
that the death certifica the by the attending photograph detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of deliv Month	ery Day Year
S, T.			entributing to death be	ut not resulting in th	ne underlying cause g	iven in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
requires that requires that een signed b	d b						1 ☐ Yes	2 □ No 3 □ Proi	bably 4 Munknown
2 0 0	lete						24a. Was an	24b. Were auto	opsy findings available
- • - •	Completed						autopsy performed?	prior to co death?	mpletion of cause of
VICION: The certificate h	Ö					26. Place of Dea	th (Check only one)	lo 1 Tes	₹₹/vo
	8	examiner? 1 157 Yes 2 ☐ No	Hospital:	nt 2 ER/Outp	atient 3 DOA		ome 5 Residence	6 Öther (Specia	W AT SCENE
ding Phys	T.	21	28a. Date of Injur (Month, Day	ry 28b. Tin	ne of 28c. Inju		28d. Describe how in		,, 111
ath.	atic	1 XNatural 5 Pending 2 Accident investigation		,		∃Yes 2⊟No			
or Attending after death. Director: Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At home, farm c. (Specify)	, street, factory, office		28f. Location (Street a City or Town, Sta	and Number or Rura ite)	al Route Number,
DIVISION To the Hospital or Attending within 24 hours after death. To the Funerel Director: Atten completely filled in by the funer	Cai Ce	29a. Certifier 1 Certifying Phy	sician: To the best of	of my knowledge, of	leath occurred at the	time, date and place	, and due to the cause(rred at the time, date a	s) and manner as s	stated.
the H iin 24 the Fi	edicai	one) 22 medical Exem	and manner sta	ited.					``i
To	2	29b. Signature and title of certifier	D. M.			.C.M.E	_	ate signed (Month,	Day, Year)
2		"Ula	te IV						2004
		30. Name and address of person who o	wike 1	N/11 I		t, Baltimo	ore, Maryla	and 21201	
	State istrar	31. Date filed (Month, Day, Year) JAN 2 8 201		ar's Signature	Sour	11			

detached sate has been signed by page 2 should be detact

this certificate has

Division of Vital Records,

or Attending Physician:

To the Hospital within 24 hours a

Physiclan/Medical þ Completed funeral director Be Certification: To after death.

Director: Aft

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 □ Probably 4 □Unknown

24a. Was an autopsy performed 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No

P M

25. Was case referred to medical examiner? 1√Xes 2 No 27. Manner of Death

5 Pending

6 Could not be determined

1 Natural

2 Accident

3 Suicide

29a. Certifie

4 CHomicide

28a. Date of Injury (Month, Day Yeer) 24/04 investigation

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 830 P

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

IL.

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cadse(s) and manner as stated.

1 Yes 2 XNO lace of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28d. Describe how injury occurred TaAS SHOT SIS JEC 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2200 SYDNEY

BACTIMORE

**Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) January 25, 2004

m dacause of death (Item 23a) (Type, Print) ss of person who complete

111 Penn Street, Baltimore, Maryland 21201

AVKNIE

State Registrar

Medical

JAN 2 8 2004

32. Registrar's Signature Brakers

			1 = For State Registrar	State	of Marylan		artment of H		d Mei	-	giene Reg. No.	2001	02037
	Dhysisi		1. Decedent's Name (First, Middle					7.11	2.	Date of Dea	ith Day	Year	3. Time of Death
	Physici /Medic	-			er C. Si	mancek				Januar	y 24	,2004	4:00 A M
<i>k</i>	Examin	er	4a. Facility Name (If not institution	, give street and n	iumber)		4b. City, Town, or	Location of D	Death		4c. 0	County of Dea	th
	F		5. Social Security Number	on Street	7. Age (In yrs.	last birthday)	Balt If Under 1 Year	imore (Date of Birtl	h	N/A 9. Bir	thplace (State or Foreign
	Funeral Director		199-09-3223	1 ⅓ M 2□F	83	Yrs.	Months Days		Min.	(Month, Day Aug. 2	. Year)	C	nnsvlvania
			Usual Residence of Decedent										
	arylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f	Director		I/A				ltimore	e Cit	_	10 - 0''		
	with tage		10e. Street and Number 616 South M	Incon Ctz	·oo+		10f. Zip Code	21224	1	1	-	en of What Co ed Sta	,
	ours after death with the Marylan rel', or Items 23a or 28a-f show Examiner must be notified at	Funeral	11. Marital Status	12. Was De	cedent Ever in U	.S. 13.	Was Decedent of Hi	spanic Origin	? (Specify	v Yes or No-		4. Race - Ame	
٥	or Iter		1 Never Married 2 Marri	ied 1 X Yes	2 □No		If Yes, specify Cubai	n, Mexican, P	Puerto Ric	an, etc.)		Black, Whi	e, etc.
5-0036	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show dical Examinat must be notified at	1 by	3 X Widowed 4 ☐ Divorced	If Yes, C Year or	Dates:	WII	1 ☐ Yes 2 ☒ No	Specify:				Specify:	White
'n		Completed	15. Decedent (Specify only highest		1)	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ition Juring most of	f working		16b. Kin	d of Business	Andustry
Z121		m	Elementary/Secondary (0-12)	College	(1-4or 5+)						Wes	stern E	Electric Co.
	filed within Hygiene. other than "	ပိ	11 Years 17. Father's Name (First, Middle,	Last)		l Ca	ble Splic	18. Mother's	Name (F	irst, Middle.	Maiden S	Sumame)	
Maryland	be data	To Be	Mathew Simano	ek						a Mura			
ary	A B E E	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a	nd Number o	or Rural R	oute Numbe	r, City or	Town, State,	Zip Code)
	and 2 ealth a n 27 lu		Diana E. Devi	.ne (Daug	hter)	199	7 Devine	Ct. G	Glen	Rock,	PA	17327	
altimore,	of Her		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation	3 DRemoval from		Place of Dispo cemetery, cres	sition (Name of matory or other place	9)	Date	•	20c. Loc	ation - City or	Town, State
Ĕ	Pages ment of ant: If It ury or o		`4 □Donation 5 □Other (Sp						Y = 1/2	27/2004	4 Di	ındalk,	Maryland
Ball	permit. Page Department Important: It sny injury o		21. Signature of Funeral Service i	Licensee	2	Di	Name and Addres	s of Facility uneral	L Hom	ne of I	Dunda	alk, Ir	nc.
	40 = * a		Megon	مارد ک	0	79	22 Wise A	ve. I	ounda	lk, Ma	aryla		222
			23a. Part1. Enter the disease of shock, or heart failure. List Immediate Cause Final	only one cause on	each line.	n. Do not ent	er the mode of dying	j, such as car	rdiac or re	spiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a M	etastat		ung Lai	ncer					3 years
	Examiner			Due to	o (or as a conseq	juence ot):							'
7 2		Jer	Sequentially list conditions, if any, leading to immediate	b. Due is	o (or as a conseq	juence of).			_				
	death certificate be executed e attending physician and id for use as the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
760,	o exe		resulting in death) Last	Due to	o (or as a conseq	uence of):							
30	physic physic the b	dlcai		d			-						
×	leath certific attending p	Physician/Med	IF FEMALE:	23c. If ves. c	utcome of pregna	ancv					20	2d Date of do	ing.
ROX	atter of for u	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	birth 2 ☐ Feta gnant at time of d	I death 3[Ectopic pregnancy Other (specify)				23	3d. Date of de Month	Day Year
o		hys	9 Unknown	9□ Unk	nown								
ຕົ	law requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	nderlying cause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ğ	w require been sig should b		Conquetive	Heart.	far hut	2			_ [1 2 Y	es 2]No 3 ☐ Pr	obably 4 Unknown
Records,	lawr as be	ple								24a. Was a autops		24b. Were au	topsy findings available completion of cause of
	Physician: The lav this certificate has al director, page 2	Completed								perfor	med? 2∕☐ No	death? 1 🗌 Yes	1
Vital	ician: cartific ector.	Be	25. Was case referred to medical examiner?	Hospital:			Otho		Death (C	heck only or	19)		
ō	Phys this ral dir	. To	1 Yes 2 No 27. Manger of Death	11		ER/Outpatier 28b. Time of		4 Nursir		5 Reside		Other (Spe	cify)
o	ding h. After fune	tlon	1 Natural 5 Pending	3	e of Injury onth, Day Year)	Injury	Work	?` ′es 2 □ No		. 50301100 11	o w iiijai y	00001100	
Division of	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could r	not bo	ce of Injury - At he	ome, farm, str	eet, factory, office		28f.			Number or Ri	ural Route Number,
	s afte	Certification:	4 Homicide	Duit	iding, etc. (Specif	(Y)				City or Town	n, State)		
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	edical (29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the	he best of my kno	owledge, death	n occurred at the tim vestigation, in my op	e, date and pl	lace, and	due to the c	ause(s) a	and manner as	stated.
	the H in 24 the F plete	ledi	one)	and ma	inner stated.								
	To To	Σ	29b. Signature and title of certifier	1. 1.			29c. License			١.		signed (Mont	
	1		Collect	MULZ	WS	- 00-1 7		1185			Janus	cry 24	, 2004
-9	1+1		30. Name and address of person Colleen Christmas	4.1.10	use of death (Item 25 Hoski)	~	Print)	10 5	2011	September .	m	lana.	d 21324
70	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Signa		7100001	1	X4, U/.	T POLICE	1 100	7	2.347
100	Registr		IAN 2.8	2004	PARTON A	S. Ro	men						

5	5.		1 - For Amend Item 4b,19b	State of Mar, 26, per ME, F	ryland H , G827	/ Depa 7,01 <u>/-28</u>	rtmen (Pich)	t of H	ealth a D <i>eath</i>	nd M	lental H	ygier Reg. 1	1e2 ()	04	02038
*	Physici		1. Decedent's Name (First, Middle, Last)	Virgini	a D). S	ill				2. Date of D Month Jan		Day 20	Year 0 4	3. Time of Death 5.00 A M
	/Medic Examin		4a. Facility Name (If not institution, give to 2000 Watervale	Road				Fore	est E	Hill			4c. County Ha:	rfor	
	Funeral Director		240 20 0141	7. Age	(In yrs. las	Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, C Oct. 2	Dav. Ye	1924	Coun	tace (State or Foreign try) ChCarolina
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD Harfor	I		Town or Loc		ill						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a	Director	10e. Street and Number				10f. Zip					_	Citizen of \	What Cour	itry?
	s 23e	era	324 E. Jarrett	SVIIIE 12. Was Decedent Ev	Road	_	Vas Dece		050	in? (Spe	acify Yes or N		JSA 14. Rac	e - Americ	an Indian.
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental hygiene. Item 27 is marked other then "nature!, or items 23e or 28e-f ehow other traumatic event, the Mudical Exament must be notified at	by Funeral	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Yes, spe		Specity:	Puerto	ecify Yes or N Rican, etc.)		Blac	ok, White, V:Whi	etc.
Maryland 21215-0036	hin 72 hou a. an "nature Medical E	Completed	15. Decedent's Edu (Specify only highest grad)	life. D	kind of wo	rk done d se retired,	luring most)		ing		Kind of B		dustry
2	Hygiene Other the		3rd 17. Father's Name (First, Middle, Last)			Cable	Co.	Oper			(First, Midd				
yland	2 should be fi and Mental H is marked off raumatic ever	To Be	Garford Lyon						V	irg	inia	D.	Holo	omb	
Mar	d 2 shoth and 7 is m		19a. Informant's Name/Relationship (Ty									1sto	n		Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 i eny injury or other tra 900.		William Sill / 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		cen	ce of Dispos netery, crem Grove	sition (Na	me of other place	9)	1/12	id For 1/04 Ty	20c.	Location -	City or To	
Baltir	permit. P Departme Importan eny injur		21. Signature of Funeral Service Licens	Conne	Il	22. Y			s of Facility	CO	nnell . Bal				eofEssex
*	Physician		23a. Part1. Enter the disease, or copper shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the cause on each line	he death.	Denot ente	er the mod	de of dying	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death
8760,	Medical Examiner ohysicien and the purial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	Due to (or as a d.	conseque	ince ot):									
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal d	leath 3 🗌	Ectopic p							te of delive	ory Day Year
	ires that t signed by d be detai	۵	Part II. Other significant conditions co	ntributing to death but	not result	ting in the un	nderlying (cause give	en in Part I.				o use cont	ribute to th	ne cause of death?
Division of Vital Records,	: The law requ cate has been page 2 shoul	Completed										opsy formed	?	prior to cor death?	psy findings available moletion of cause of
Zi.	sician: Th certificate irector. pag	o Be	25. Was case reterred to medicat examiner? 1 ☐ Yes 2⊠ No	lospital: 1 ☐ Inpatien	+ 2 N E	R/Outpatient	t 3□ D	Othe			n (Check onl)		6 (3 07)+h	or /Specif	Son's Home
on of	iding Phys th. : After this funeral di	ıtlon: To	27. Manner of Death 1) Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28b. Time of Injury		28c. Injury Work			28d. Describe				y boil 3 lkale
Divisi	al or Attendi s after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injur building, etc.	ry - At hom (Specify)	ne, tarm, stre	eet, tactor	y, office			28t. Location City or T			er or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C		sician: To the best of ner: On the basis of a and manner state	examination										
)	To the To the comp	Me	29b. Signature and fifth of certifier	Zutin]	D 4	9 number 446	7		29d.	Date signe	d (Month,	Day, Year)
	3		30. Name and address of person who co	ompleted cause of de	ath (Item 2	23a) (Type, 1					St 59	e 70	08	But	t. WID
	Sta Regist		31. Date tiled (MANDa 2 Year 200	32. Registra	r's Signatu	ire .	de)						•		

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. **Physician** John Robert Sterner 7:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LongView Nursing Home Manchester Carroll 8. Date of Birth Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1₫M 2□F 218-38-4388 68 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Carroll Manchester Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4850 Stoney Lane 21102 U.S.A. Items 23a death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming Pages 1 and 2 should be filed w trment of Health and Mental Hygie trant: If item 27 is marked other t hjury or other traumatic event. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Henry Sterner Naomi Virginia Snyder ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert E. Sterner - son 4214 East Main St. Lineboro, Md. 21088 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Lutheran Cem. Jan. 28,2004 * 4 ☐ Donation 5 ☐ Other (Specify) Manchester, Md. 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Chapel P.A. Manchester, Ellendo South Charmil Dr. Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastic Physician Corci more /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Citease of injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed thours after death. anding physician and use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 Ulaknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 ☐ Yes 2 ☐ No 2 □No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funeral D filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) 0 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address má 2111 12000 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Day Month Vear Physician 2004 Lvdia Α. January 26, Thompson 1:50 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charles County Nursing & Rehab Center Charles If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 □ F 281-44-2255 Director 14, 1918 Ohio Usuel Residence of Decedent with the Maryland f Health end Mantal Hygiena. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TyYes 2 □ No Funeral Director Charles Maryland Waldorf 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours efter death w Department of Haalth end Mantal Hygiena. Important: if Item 27 is marked other than "natural" any injury or other traumatic events and place. 2525 Ryce Drive 20601 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. I ☐ Yes 2 XNo 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: 2 Specify: 3 X Widowed 4 Divorced Yeer or Dates: White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Lincoln Weekley Martha Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2525 Ryce Dr., Waldorf, MD 20601 Ruth Cottrill (Daughter) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Hills Burial Park | 1/31/04 4 ☐ Donation 5 ☐ Other (Specify) Canton, OH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reed Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Preumonia Examiner Due to (or as a consequence of): Physician/Medical Examine ettending physician and for use es tha burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68758 Attending Physician: The law requires that the death certificate Due to (or as a consequence of): resulting in death) Last ed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Alzheimer's dementie 1 Yes 2 No 3 Probably 4 Unknown signed be del à Completed 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? certificete has t liractor, page 2 s 2 No 1 ☐ Yes 2 ☐ No diractor Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 XNursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending s after death.
I Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 6 filled in within 24 hours a
To the Funeral C
completely filled To the Hospital 1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signeture and title of cedifier 29c. License number 29d. Date signed (Month, Day, Yeer) D005809S 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Tonya Hardy, 11345 Pembrook Sq. Station Waldorf, MD 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State JAN 28 Registrar

			For State Registrar	State of Maryland		rtment of He			ene 20	04	02041
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	Physicia		William	Tutton	Jr			January			05:05P M
ÿ	/Medic Examin		4a. Fecility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
	_xa	•	452 Longtown Cour	rt.		Glen Bur	nie		Anne	Aru	ınde1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign try)
	Director		215-07-8250	u 2□F 86	Yrs.			Sep 10,	1917		MD
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c City 1	Town or Lo	cation				1	Od. Inside City Limits
	aryla shov	_									1 ☐ Yes 2 ☐ YNo
	286-1 286-1	ecto	MD Anne Aruno	iei Gi	en Bu	10f. Zip Code		10	g. Citizen of W	hat Coun	trv?
	with a or 3	古		. 4					U.S.A		•
	s 23	Funeral Director	452 Longtown Cour	T. 2. Was Decedent Ever in U.S.	13. V	21061 Vas Decedent of His	panic Origin? (Sp	pecify Yes or No-	14. Race	- Americ	an Indian,
_	ter d	Į,	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	"	Yes, specify Cubar	i, Mexican, Puero	Rican, etc.)		k, White,	
2	urs at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify	Whi	te
9500-612	e filed within 72 hours after death with the Maryland of Hygiene. other than "natural", or Items 23a or 28e-f show ent, the Masical Executer count by notified at	ted	15. Decedent's Educa		16a. Deced	lent's Usual Occupa kind of work done di	tion	kina 1	6b. Kind of Bu	siness/Inc	dustry
7	hin 7	ple	(Specify only highest grade and Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)		, , , ,			
7	gien gien er th	Completed		5+	Sel	f Employe			Resta		t
2	al Hy d oth	Be (17. Father's Name (First, Middle, Last)					ne (First, Middle, M	laiden Sumam	9)	
Z	Ment Ment arked	ဥ	William Tutton, Sr					ie Appel			1
Maryland	2 she and ls m		19a. Informant's Name/Relationship (Type Mrs. Katherine Tut			g Address <i>(Str</i> eet a Longtown				State, Zip 210	
2	and lealth m 27 her to					sition (Name of	Court		Oc. Location -		
baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hylgiene. Department of Healih and Mental Hylgiene. Interpretately the marked other than "natural, or Items 23a or 28e-1 show amy injury or other treumatic avent, the Modical Examination and page. Quoe.	-	20a. Method of Disposition 1)☐ Burjal 2 ☐ Cremation 3 ☐ Rei	moval from State	netery, cren	natory or other place) Outi	23 _R	altimor		
	t. Pa rtmen rtant:		4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Fuheral Service Licensee			ge Cemete		14			
g	Depa mpo mny ir		21. Signature of Puneral Service Licensee	Mu13104	/	. Name and Address					
100			23a. Part1. Enter the disease, or complication							עויו	Z1U61 Approximate
			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	- /		-				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to for as a consequent	The second second	arran	DON'S	Dinear	6		
	Examiner			Due to tot as a conseque	e (emcer					
		F	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):	SITIO				-	
1	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.							2	
لت	be secuted ician and burial-transit	EX	resulting in death) Last	Due to (or as a conseque	nce of):						
3	ate he	cal	d.								
9	ng pt ng pt s as ti	Physician/Med	IF FEMALE:								
ROX	eath certific attending pl	an/I	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnance1 Live birth 2 Fetal d	eath 3	Ectopic pregnancy			23d. Date Mor	e of delive nth	ry Day Year
	at the dea by the at tached fo	sici	1 Yes 2 No	4☐Pregnant at time of dea 9☐ Unknown	th 5∟	Other (specify)					
J.	d by letact	Phy	Part II. Other significant conditions conti	ributing to death but not result	ing in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contr	ibute to th	ne cause of death?
S.	ires that signed t	þ	Partit. Other significant contactions contact			,		1 □ Ye	s 2□No	3 🔲 Prob	ably 4 Minknown
Ö	w requir been si should I	etec						24a. Was an	24h V	Vere auto	nev findings available
Records,	0 - 2	Completed						autopsy	led?	eath?	psy findings available inpletion of cause of
	icien: The certificate hi rector, page						00 Plana 4 Pag	1 Yes 2		Yes	2 L No
of Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Ho	ospital:	R/Outpatier	t 3 DOA Othe		ome 5 Reside		r (Specifi	()
	Physicie r this cert rral direct	-	27. Manner of Death	28a. Date of Injury 2	8b. Time of	28c. Injury	at	28d. Describe ho			,
0	ding I th. : After s funer	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 🗆 Y	res 2 □No				
Division	Attending it death.	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Str. City or Town	eet and Number State)	er or Rura	l Route Number,
	s afte	Certification:	4 - Homicide	building, sic. (opcony)					, = ,-,-,		
	hour uner uner			cian: To the best of my knowler: On the basis of examination							
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	one)	and manner stated.		29c. License		-	d. Date signed		
	To Too	2	29b. Signalure and title of certifier	D				28	Date signed	1	1
			4 Jum	. D.		D541	XIX		1122	10,	1
	M		30. Name and address of person who con	CRAIN HWY,	23a) (Type,	201 Gle	n Burnie	MD 21	061		
	10		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	Print) Gle					
	Sta Regist		IAN 2 R 2	nos Denero	, ,	4 Som	11.1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** THOMPSON EDGAR 21 2004 Jan /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MEDICAL Baltimere
If Under 1 Year | If Under 24 Hrs. Center 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Days Hours 1 M 2 ☐ F 56 Yrs MASSA Director Usual Resid death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be notified at once. 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA 100d by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes 2□ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Divorced 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be 1050N (Type, Print) 19b. Mailing Address (Swet and Number or Rural Route Number, City Method of Disposition 200. Place of Disposition (Name 20c. Location - City or Town, State 3 Removal from State Parrison * 4 □ Donation 5 □ Other (Specify) tores-21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Acu Physician Coronary /Medical Due to (or as a consequence of): **Examiner** 30 117.4 Myocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit OFONAL and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ate has been signi page 2 should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy perform 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 VER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospitel 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier Doo 57354 Ja 2004 D

DHMH 17 Rev 1/2001

State Registrar Hyung

31. Date filed (Month, Day Near)

s of person who completed cause of death (Item 23a) (Type, Print)

2004 32. Rassar's Signature

			For State	State of Marylan	•	rtment of Health a	and Mental Hyg	giene	02010
			Registrar 1. Decedent's Name (First, Middle, Last,)	Cen	ificate of Death	2. Date of Dea	Reg. No. 4 UU4	3. Time of Death
	Physici		1/0-1		rnei		Month JANUAR	Day Yeer	- 211
	/Medic Examin		4e. Fecility Name (If not institution, give		ital	4b. City, Town, or Location of The Lines	of Death	4c. County of Deeth	
1:	Funeral Director	9	18-26-2717	x 7. Age (In)rs.	last birthday) Yrs.	Months Days Hours	Min. 8. Date of Birth (Month, De)	1928 Ma	nplece (State or Foreign untry) THANA
	Maryland -f show	tor	Usuel Residence of Decedent 10a State 10b. County	10c. Cit	y, Town or Loc	ation			10d. Inside City Limits 1 Yes 2 No
	death with the Maryland rms 23a or 28a-f show Fraust be notified at	Funeral Director	10e. Street and Number 1047 Mar la	w. Drive	,	10f. Zip Code		10g. Citizen of What Cod	untry?
36	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, If a Medical Examinar must be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 2 Wildowed 4 Divorced	12 Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give	If	as Decedent of Hispanic Orig Yes, specify Cuban, Mexican ☐ Yes ☐ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Amer Black, White Specify.	
21215-0036	within 72 hour ene. than "natural he Medical En	Completed b	15. Decedent's Edu (Specify only highest grad Elements y/Secondary (0-12)		(Give k	ont's Usual Occupation ind of work done during most O NOT use retired)	of working	16b. Kind of Business/I	ndustry
	be filed within tal Hygiene. d other then event, the Me	Be Com	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name (First, Middle,	HIVOC Maiden Sumame)	te
Maryland	nould b	To I	William A. Barr	1es	405 44-11	Jac	quetta G	ood	
Ma	1 and 2 sho Health and Iom 27 Is m		19a. Informant's Name/Relationship (T)	er Daughter	1047	Addrass (Street and Number	nive Ba	r, City or Town, State, Z To Min 21:	0/_2
ore,	ges 1 ar 1 of Hea 1f Item or other		20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ F	1 .	Place of Disposi cemetery, cremi	ition (Name of atory or other place)	Date	20c. Location - City or 1	Town, State
altimore	P. Braga		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licens	(ja)	MISON	torestember	1/27/04	Wings Mi	$ls_{p}MD$
Ba	permit. Departr Importa any inji		Ven to	Suit	V	aughni Cor	Dd. Palte	on MADOLA	ices)
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the deet ne cause on each line.		the mode of dying, such as \mathbb{R}^{N}	cardiac or respiratory are	est,	Approximate Interval Between Onset and Death
3	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		- 116°W-12		- aays
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bue to (or as a consequence)		LIDNEY DIS	SEASE		3 years
1,0928	cate be executed physicien and the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq	ruence of):				
289	g physias the	edlcal		J					
P.O. Box	that the death certifii ed by the attending f detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3 □E	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	very Day Year
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions con	ntributing to death but not res	ulting in the und	derlying cause given in Part I.		bacco use contribute to es 2 \hat{\mathbb{G}}\text{No} 3 \square \text{Pro}	the cause of death?
Vital Records,	The ate h page	Completed					24a. Was a autop: perfor	med? death?	opsy findings available ompletion of cause of
Vita	lcian: certific ector.	Be	25. Was case referred to medical examiner?	Hospital:		Other	of Death (Check only or		
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ⊠Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 1		ence 6 Other (Speci ow injury occurred	ify)
Divisi	al or Atter s after dea sl Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stree by)	et, factory, office	28f. Location (S City or Tow	treet and Number or Rui n, State)	ral Route Number,
	Hospin 24 hour Funer etely fills	edical (29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medicel Exemi	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death attion and/or investigation	occurred at the time, date and estigation, in my opinion, deat	d place, and due to the c th occurred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier	600		29c. License number		9d. Date signed (Month	
	1			ingta, MI			946		
	6		30. Name and address of person who co	BALTIMO	RE,	MD 21218	201 E UNIV	ERSITY PAR	KIKWAY,
ń	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's Signa	aute L		· 7		

			State of Maryla	and / Department of Health and	Mental Hygiene
		•	1 - For State Registrer	Certificate of Death	Reg. No. 2004 02044
	Physicia	an	Decedent's Neme (First, Middle, Last)	1.	2. Date of Death Month Day Year 3. Time of Death
	/Medic	al	Frank Wilbert Vale 4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Deet	JANUALY 22, 2004 0830 M
	Examin	er	Union Menorial Hospita	L Butinon	
	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	
Diffe.	Director	2	20-30-0851 RM 20F 65	Yrs.	3/1/34 Bough (201/12
	yland			City, Town or Location	10d. Inside City Limits
	8a-fs	Director	MD	baltimore	10g. Citizen of What Country?
	with the		1622 Homestead Street	10f. Zip Code	USA
	death	nera	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.) 14. Rece - American Indian, Black, White, etc.
36	hours after death with the Maryland ture!, or Items 23e or 28a-f show al Examiner must be multified at	y Fu	1 Never Married AMarried 1 Yes ONO If Yes, Give Year or Dates:	1 ☐ Yes ☐No Specify:	Specify: Block
21215-0036	72 hours aft "naturel", or	Completed by Funeral	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
215	within 7: lene. than "n	npie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wo	Solt Co dough
	filed w Hygier ther th		17. Father's Name (First, Middle, Last)	18. Mother's Nai	me (First, Middle, Maiden Sumame)
lan	ould be Mental Marked o	To Be	Charles Valentine	ESSI	eJohnson
Maryland	and and self		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Re	ural Route Number, City or Town, State, Zip Code)
_	s t and of Health Item 27 other tr		20a. Method of Disposition 20	Place of Disposition (Name of	Date 20c. Location - City or Town, State
Jor	0 = 5		1 Suriel 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	cemetery, crematory or other place)	29/04 RolloMI
Baltimore	permit. Peg Department Important: any injury c		21. Signature of Funeral Service Licensee	24 Name and Address of Facility	e Funeral Services
8	Ded July		Varfer Drue	- 4005 YORK	Cor respiratory arrest. Approximate
			23a. Part1. Enter the disease, or complications that caused the d shock, or heer failure. List only one cause on each line. Immediate Cause (Final		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a con-	ory Right Heart Fair	11 days
	Examiner		Sequentially list conditions, b.		
7	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitted events	sequence of):	
×	execu en and rial-tra		that initiated events resulting in death) Last Due to (or as a con-	sequence of):	
7	eath certificate be executed attending physicien and for use as the burial-transit	lical	d		
89 x	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pre	egnancy	23d. Date of delivery
Вох	death a atten	ician	in the past 12 months? Compared to the past 12 months? 1	Fetel death 3 ☐ Ectopic pregnancy	Month Day Year
P.O.	w requires that the de been signed by the s should be detached	hys	9 Unknown		
S,	ires th signed 1 be de	by	Part II. Other significant conditions contributing to death but not Renal Failure.	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4★Unknown
COL	w requ	Completed by	RESPIRATORY Failure		24a. Was an 24b. Were autopsy findings available
Re	The te h	фшо	SERSIS		autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
/ital	cian: ertifica ector, p	Be	25. Was case referred to medical examiner?	Others	ath (Check only one)
of	Phy rald	To.			Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
ion	Attending it death.	ation	27. Manner of Death 1 Description 28a. Date of Injury (Month, Day Yea.) 2 Accident 1 Accident	Injury Work? M 1 Yes 2 No	
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, street, factory, office opecify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ω	pitel ours af		29a. Certifier 1 Cartifying Physician: To the best of my	knowledge, death occurred at the time, date and place	e and due to the cause(s) and manner as stated.
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical			urred at the time, date and place, and due to the cause(s)
	To the To the comp	×	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	()		Selecia Nichalso	AT 2438946	
	4		30. Name and address of person who completed cause of death of the state of the sta	Parkway Baltoman	icholson, M.D. Md 21218 - 2895
5	Sta		31. Date filed (Month, Day, Year) 32. Registrar's S	ignature	
Divi	Regist	rar	JAN 2 8 2004 - Lien	wa to foots	,

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of M	-			of Health of Death		ental Hy	giene Reg. No	/ [] []	-\$	02045
			1. Decedent's Name (First, Middle, I	ast)						2. Date of De	ath	ay Yea		3. Time of Death
	ysicia Medic		Valerie A. V	arner						Janua	ry	24 200	4	2:42p M
	amin		4e. Fecility Name (If not institution, g					vn, or Location			40	County of De	eth	
			3807 E. Prat 5. Social Security Number 6		je (In yrs. last bin	th day)	If Under 1 Y	timor	e r 24 Hrs.	8. Date of Bir	*6	n/a	liebala	on (Chain on Familia
	eral ector	1	219-52-4076	1 M 2 St.		Yrs.		ays Hours	Min	9-8-1	v Year	, , , ,	Country	ce (State or Foreign) land
land	=		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation						10d	I. Inside City Limits
Mary -1 she	fied	tor	MD n/a			Bal	timor	re .						1★Yes 2□No
h with the	at be not	al Director	10e. Street and Number 3807 E. Pratt	Street			10f. Zip Co	de 21224	· · · · ·			tizen of What (Country	n
ire, Maryland 21215-0036 st and 2 should be filed within 72 hours after death with the Maryland if setath and Mantal Hygievier. Item 27 is marked other than "natural", or items 23e or 28e-f show	Examinerna	by Funeral	11. Marital Status 1	12. Was Decedent Armed Forces? 1 Yes 257 If Yes, Give Year or Dates:		lf If	/as Decedent Yes, specify ☐ Yes 2∑	of Hispanic Or Cuban, Mexica No Specify	ın, Puerto F	cify Yes or No Rican, etc.))-	14. Race - Ar Black, Wh Specify:		3.
5-0 72 hg	dical	Completed	15. Decedent's (Specify only highest	Education prade completed)	16a.	(Give k	ent's Usual O	one during mo.	st of working	ng	16b. K	(ind of Busines	ss/Indus	stry
121 Within	a Me	Idu	Elementary/Secondary (0-12)	College (1-4or	5+) T	'ife. D	O NOT use re	etired)		,	M:	arylan	ı ba	Nat'l
filed V	nt, th		12th 17. Father's Name (First, Middle, La	st)		CII	-CT	18, Moth	er's Name	(First, Middle	1		iu i	Nac 1
ylano ould be Mental	ic eve	To Be	Harold Varner	•						razia				
Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Minorian: If Item 27 is marked other than "natural", or	Iraumai		19a. Informant's Name/Relationship Ann Varner	(Type, Print) moth							-	or Town, State		
or 1 and 2 of Health au	other		20a. Method of Disposition		20b. Place of	Dispos	ition (Name o	ratt S		altimo		MD ocation - City of		224 n, State
Baltimore permit. Pages 1 Department of H Important: If Its	ury or		1 Burial 2 □ Cremation 3 Comparison 5 □ Other (Specific Specific Specif			-	atory or other nisla		1/30/	2004	Bal	timor	e,M	ID
Salt ermit. epartr	any Inji		21. Signature of Funeral Service Lice	ensee	inde II	22.	Name and A	ddress of Facil	ity Jos	eph N	. Z	anninc	J	r.
m 205	= a	1/4	23a. Part1. Enter the disease, or co	- Janne	d the death. Do s							more,		21224
Physic /Med Exam	lical		shock, or heaf failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each li	a consequence	٤	o &	Li V		respiratory a	rrest,		Ir	pproximate tterval Between Inset and Death
		Examiner	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or es	s consequence :	il):								
8760, cate be executed only sician and	the burial-transit	dical Exa	resulting in death) Last	Due to (or as	a consequence of	of):								
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p	d be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregn Other <i>(specif</i>)					23d. Date of d Month	elivery Da	ay Year
rds, P. quires that n signed by	uld be deta	d by Pr	Part II. Other significant conditions	contributing to death b	out not resulting in	the und	derlying cause	e given in Part	l.	23e. Did t				cause of death?
Division of Vital Records, I or Attending Physician: The law requires tatler death. Director: After this certificate has been signe	page 2 should	Completed								24a. Was autor perfo		prior to death?	comp	y findings available letion of cause of
/ita cian: ertifica	ector,	Be	25. Was case referred to medical examiner?	Managed.			-		e of Death	(Check only o				
of \ Physi this o	al dire	2	1 Yes 2 No	Hospital:	-							6 □Other (Sp	ecify)	
Division I or Attending I after death. Director: After	he funer	atlon	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigat		y Year) Ir	njury		Injury at Work? 1 ∐ Yes 2 ∐		8d. Déscribe I	now inju	ry occurred		
Divis	d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of In	ury - At home, fai c. (Specify)	m, stree	et, factory, off	ice	2	8f. Location (S City or Tox		nd Number or F	Rural R	loute Number,
To the Hospital within 24 hours	completely filled in by the funeral director, page 2	edical	29a. Certifier 17 Certifying (Check only one)	Physician: To the best aminer: On the basis o and manner st	t examination and	, death of	occurred at the estigation, in r	ne time, date ar ny opinion, dea	nd place, as ath occurre	nd due to the d at the time,	cause(s date and) and manner a d place, and du	as state ue to th	ed. e cause(s)
To th To th	сошо	Me	29b. Signature and title of dentifier	in 0				cense number	-			te signed (Mor		y, Year)
3			30. Name and address of person wh		leath (Item 23a) (9 Ze (fe			3al time	re M	10 21	124	(
	Sta	le	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature									
_e Re	gistra	ar	JAN 28	2004	· As	E	soll s							
DHMH 17 R	Rev 1/20	01			4	GINA	L							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 9:55 PM J<u>anuary</u> 24,2004 Margaret Anna Wolf /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dorsey Center Catonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 212-03-8003 Director 90 October 23,1913 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Exprimer: just by notified at 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane Brookside 203 21228 United States 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status 2 should be filed within 72 hours after a and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) social security Personnell worker administration 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 Is marked ott jury or other treumatic even John G. Dillman May E. Hayne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Roszell - friend 869 Willys Drive, Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Bayview Crematory 1/27/2004 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listjonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pue to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine burial-trans# that initiated events been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> heart failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 21 No 1 Yes 2 No or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Mursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending s after decral Director: Alte 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 25 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D30989 Myla M Carporter, MB Choice allivenotos Lanz Mouden 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 8 2004 Registrar

			State of Maryla	-	artment of H			ene 2004	02047
			Registrar 1. Decedent's Name (First, Middle, Last)		7111100110 01 1		2. Date of Death		3. Time of Death
	Physicia	an		/gant			January	23 2004	10:50 P M
4	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	oundar y	4c. County of Deat	
	Examin	er	7979 Holly Road			sadena		Anne	Arundel
	Euporol		, J. C. T. J. IV.	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
e ^c .	Funeral Director		176-14-8520 ^{1⊠M 2□F}	81 Yrs.	Months Days	Hours Min.	(Month, Day,	1922	PÂ
	υ		Usual Residence of Decedent						
	nylan how			City, Town or Lo	ocation				10d. Inside City Limits
	B Ma	cto	Maryland Anne Arundel			Pasadena			1 Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a		7979 Holly Road			21122		USA	
	tams	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe In, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	or i	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
8	within 72 hours after death with the Maryland ene. Than "natural", or Itama 23a or 28a-f show ha Medical Evantiner mast ke mutified at	De De	15. Decedent's Education	16a Dece	edent's Usual Occup	ation	1	6b. Kind of Business	
7	n 72	olet	(Specify only highest grade completed)	(Give	e kind of work done of DO NOT use retired	during most of worki	ng	TOD. TRING OF DOGINGOUS	modelly
7	with there.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	l F	Purchase A	Agent		Bethlehem	Steel
ō	Hyg other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	faiden Sumame)	
a	id be	To B	Percival Weygant			Phoebe		Steel	
37	shound M		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street	and Number or Rura		City or Town, State, 2	Zip Code)
Ž	alth a		Patricia Keller (daughter)	882!	5 Ft. Smal	llwood Rd.	., Pasad	ena, MD 21	122
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any riqury or other traumatic event. The Medical Examination in any injury or other traumatic event. The Medical Examination in an angle.		202. 11.00.102 01 - 10.001	. Place of Dispe	osition (Name of ematory or other place	э) Jan.	27 2	20c. Location - City or	Town, State
Ĕ	Page nent c nt: M rry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	edar Hi	11 Cemete	,		Baltimore.	Maryland
ä	mit. partir porte y inju		21. Signature of Funeral Service Licensee	2	2. Name and Addres			Funeral H	
ä	Depa Impo any i		Hu I do		3111 Mour		_	ena, MD 21	
			23a. Part! Enter the disease, or complication, that caus the de shock, or heart failure. List only one caus, on each I e.	ath. Do not en	iter the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician	01	Immediate Cause (Final disease or condition	Lange	arcin	com of			Onset and Death
	/Medical		resulting in death) a. Due to (or as a cons	-	in con	07104			
0	Examiner		Sequentially list conditions, b.						
.77	D #	ner	if any, leading to immediate cause. Enter Indertying Cause Chiere in his y	equence of):					
W	ind trans	Examiner	that initiated events c.						
3	b exe ician ar burial-t	m	resulting in death) Last Due to (or as a cons	equence of);					
8760,	ate hys	Physician/Medical	d						
9	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Med	IF FEMALE:						
Вох	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	etal death 3	□Ectopic pregnancy			23d. Date of del Month	ivery Day Year
0	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	#death 5	Other (specify)				,
<u>a</u> .	that the de led by the a detached t		Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause give	en in Part I	23e. Did tob	acco use contribute to	the cause of death?
ds,	signe d be	l by		3	on to the same of		1 ☐ Ye	•	
Ö	w requir been si should	etec				·	-		
Sec.	e law has b	Completed					24a. Was ar autopsy perform	prior to	topsy findings available completion of cause of
Vital Records,							1 ☐ Yes 2	No 1□Yes	2 □ No
Ĭ.	Physicien: rthis certific ral director,	Be	25. Was case referred to medical examiner?		other Other	26. Place of Death er:			
ō	Phys this ral dir	-T	1 Tes 2 No 1 Inpatient 2	ER/Outpatie 28b. Time o	ent 3 DOA	4 Nursing Hor	ne 5 1 eside: 28d. Describe ho	nce 6 Other (Sperwinium occurred	cify)
G	ding h. After funer	ion	1 Natural 5 Pending (Month, Day Year,) Injury	Worl			,	
Division	f or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - A	t home, farm, st			28f. Location (Str	eet and Number or Ru	ıral Route Number,
Ö	or the	Certification:	4 ☐ Homicide determined building, etc. (Spe	icity)			City or Town,	, State)	
	Hospitel		29a. Certifier Certifying Physician: To the best of my	knowledge, dea	th occurred at the time	ne, date and place, a	and due to the ca	use(s) and manner as	stated.
	P Ho 1 24 F 19 Fulletely	edical	(Check only Medical Exeminer: On the basis of exam one) and manner stated.	ination and/or in	nvestigation, in my o	pinion, death occurre	ed at the time, da	te and place, and due	to the cause(s)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier		29c. License	e number	/ \ 29	d. Date signed (Mont	h, Day, Year)
)	2-4		Enil & Kunow MI	1	D43	6231	MD)	1/26/0	4
	11)	- 8	30. Name and address of person who completed caus of death (I	tem 23a) (Type	, Print)	111	1 1 1	17	1
			Erik L. Bussell M. N. 77	11 Qua	intertie	ld Kola	ute/1.61	en Rurniel	712/06/
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Sig	gnature					
	Regist	rar	JAN 2 8 2004 Same	a G	home &	11			

		1	For State Registrar	State of	Marylan			t of Hea e of De		Mental Hy	giene Reg. No.	2004	02048
	Physicia		Decedent's Name (First, Middle, La FANNIE		KERSON					2. Date of De. Month 1/20	Day	Year	3. Time of Death (912P M
1	/Medic	al -	4a. Fecility Name (If not institution, giv				4b. City,	Town, or Loc	ation of Dea			unty of Death	(3121
	Examin	er	(GENESIS) HAM				GL	EN BU	JRNIE		I	A.A.C	
	Funeral Director		5. Social Security Number 6. S 215 22 7557	ex □м 2√2 F	7. Age (In yrs. I 87	ast birthday) Yrs.	If Under Months		Jnder 24 Hr ours Mir		h y, Year) 6	9. Birth	place (State or Foreign VA.
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					1	10d. Inside City Limits
	Mary Fed a	to	MD.			BAL	TIMO	RE					X Yes 2 No
	ith the or 284	Oired	10e. Street and Number				10f. Zip					of What Cou	ntry?
	sath w	eral	911 LEADENHAL		(202) Ident Ever in U.	S 13 1	1	1225	nic Origin? (Specify Yes or No	US - 14.	SA Race - Ameri	can Indian,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show othar traumatic event, the Madical Examinations in milling a	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Yes If Yes, Giv Year or Da	rces? 2.⊠No e		If Yes, spec	erry Cuban, M	exican, Pue	nto Rican, etc.)		Black, White, ec <i>ify:</i> BI	etc. LACK
2-0	72 hor	eted	15. Decedent's E (Specify only highest gr			(Give	kind of wor	al Occupation	g most of w	orking	16b. Kind	of Business/In	dustry
21215-0036	within ane. then "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	CAFE	se retired) CTERIA	1		BALT	ro. sc	CHOOL
	should be filed withind Mental Hygiene. I marked other then umatic event, the	Be	17. Father's Name (First, Middle, Last CORNELIUS)	ERSON			18.	Mother's Na	ame (First, Middle,	Maiden Su KERS(
Maryland	id 2 shoul	은	19a. Informant's Name/Relationship (MARY SHERROD	Type, Print)						Rural Route Number			
re,	of Health Item 27		20a. Method of Disposition	70		lace of Dispo emetery, crea	osition (Nan	ne of ther place)		Date		ion - City or T	
imo	Pages ment of I ant: If Its ury or o		1 Donation 5 Other (Speci		State	ARBUT				24/04		JTUS,	
Baltimore,	permit. Pages 1 a Department of Hea Important: If Item any injury or otha		21. Signature of Funeral Service Lice C.A.ESTEP	Ca	Gliff					UNERAL BALTO		P ₂ 121	
*			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that c one cause on e	aused the death ach line.	n. Do not en	ter the mod	e of dying, su	ich as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	Examiner			Due to	(Or as a conseq	delice oi).							
	ם פ	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):							
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9	as as	Aedic	IF FEMALE:										
.O. Box	death e atter d for u	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 yes 2 No	1 Live t	tcome of pregna pirth 2 Peta nant at time of d own	Ideath 3	□Ectopic pr □ Other (sp				230	I. Date of deliv Month	ery Day Year
Q	S C O	d by Ph	Part II. Other significent conditions	contributing to d	eath but not res	ulting in the u	underlying c	ause given ir	Part I.	23e. Did 1	_	,	the cause of death?
Division of Vital Records,	e law has b le 2 st	mplete								24a. Was	an 2 psy prmed2	death?	opsy findings available ompletion of cause of
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f Vi	d is	To B	examiner? 1 Yes 2 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatie	nt 3□ DC	Other		Home 5□Resi		Other (Speci	fy)
ion o	Jing After fune		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	,	of Injury th, Day Year)	28b. Time o Injury	of 2	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe	how injury o	ccurred	
Divis	al or Attends after death	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4 289. Place	of Injury - At hing, etc. (Specif	ome, farm, st	reet, factor	y, office		28f. Location (City or To		lumber or Rur	al Route Number,
	To the Hospital or Attent within 24 hours after dealt To the Funaral Director: completely filled in by the	Medicai (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	miner: On the b	e best of my kno easis of examina ener stated.	owledge, dea ation and/or in	th occurred nvestigation	at the time, on, in my opinion	date and pla on, death oc	ice, and due to the curred at the time,	cause(s) an date and pl	nd manner as a	stated. to the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	0			29	c. License nu			-	signed (Month,	Day, Year)
	,		7	1) femus	-			1) 5	0641		Janu	(1)	11 2004
7	6		30. Name and address of person who Ramesh Saba	cpa The	3 900	Erch	nan	Ave	nue	Balti	move	Mary	May 21213
	St Regist	ate	31. Date filed (Month, Day, Year)		Registrar's Signa	M	1		-			,	

		1 - State Registrar	State of I	Maryland /		artment of H		ind M		giene Reg. No. 2 (004	0204
Physici /Medio		Decedent's Name (First, Middle, Las	•	nevieve	Wr	ight			2. Date of Dea Month	Jan 19, 20	Year 104	3. Time of Death 8:20 Pm.
Examin			land Genera	al Hospital		4b. City, Town, or		Balti	more	4c. County	1	N/A
uneral irector		210-00-3300	9X 7 □ M 2 □ XF	Age (In yrs. last I	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Apr 2	Year) 24, 1955	9. Birthi	olace (State or Foreig ntry) Maryland
-f show fied at	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland	N/A	10c. City, To	own or Lo		Baltimor	e				10d. In <i>s</i> ide City Limit
3a or 28a at be noti	Il Director	10e. Street and Number 3212 Walbrook Ave #1	1 .			10f. Zip Code	212	216		10g. Citizen of V	Vhat Cou	•
al', or Itams 2 Exeminer mu	by Funeral	11. Marital Status 1 Mever Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 [If Yes, Give Year or Date:	<i>s?</i> ⊒ h Xo		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ N¥o	ispanic Origin, Mexican,	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	14. Rac Blac Specify	k, White,	can Indian, etc. Black
is marked other than "natural", or itams 23a or 28a-1 show eumatic event, tre Middical Exteninar mast bu notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4d		(Give	dent's Usual Occupa kind of work done of DO NOT use retired HOI	during most		99	16b. Kind of Bu		dustry
irked other	To Be C	17. Father's Name (First, Middle, Last)	y Dingle				18. Mother	's Name		Maiden Sumam erine Bra		
27 is me ar treum		19a. informant's Name/Relationship (7) Beatrice Purdie	ype, Print)	15		ng Addres <i>s (Street a</i> 1319 Franklin t						Code)
Important: If item 27 is marked any injury or other treumatic a 2005e.		20a. Method of Disposition 1			of Dispo tery, cren	sition (Name of natory or other plac Mt. Zion	e)	Da	01/26/04	20c. Location - Land	•	own, State , Maryland
Importa any inju 2005a.		21. Signature of Eugeral Service Licens	Step	elhin va ani:	22	Name and Addres			ral Home F altimore, M	P.A.		
edical miner the prial-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I ary, leaving to turnediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	ling	e of):	rcino	rec					Interval Between Onset and Death
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an signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death	but not resulting	in the un	iderlying cause give	n in Part I.			_	ibute to th	ne cause of death? ably 4 @Unknow
page 2	Completed						· · · · · · · · · · · · · · · · · · ·		24a. Was a autops perform	nea?	eath?	psy findings availab npletion of cause of 2 No
To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Hospital: 1 Inpa 28a. Date of In (Month, D 28e. Place of I building,	ijury 28b.	Time of Injury		r: 4 🗆 Nur:	sing Hom 28	3d. Describe ho	ence 6 Other	bd	/) I Route Number,
uneral ly filled	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the besiner: On the basis and manner.	or examination a	je, death ind/or inv	occurred at the tim estigation, in my op	e, date and inion, death	place, ar	nd due to the ca	tuse(s) and mar ate and place, a	nner as st nd due to	ated. the cause(s)
e Fe	Me	29b. Signature and title of certifier		\		29c. License	number		25	9d. Date sig id	(Month,	av. Year)
To the F complete		· Okall	1he	MI			89	498		11	191	04

Registrar

Virginia

Wiles

m

32. Registrar's Signature

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Overmix

JAN 2 8 2004

Mokey

31. Date filed (Month, Day, Year)

			For State	State of Marylan		rtment of Healt tificate of Dea			2111	14 02051
			Registrar 1. Decedent's Name (First, Middle, L	ast)		inicate of Boa		2. Date of Deat		3. Time of Death
	Physici		Mary	woote	\sim			Janua	Day Ye	ar 9:00PM
	/Medic		4a. Facility Name (If not institution, g			4b. City, Town, or Locat	tion of Death		4c. County of D	
			Harber	HOSPITAL C	enter	Balti	more			
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs.	***	If Under 1 Year II Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		214-24-0457	80	Yrs.			07 04	23	NĈ
200	* =		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
Man	4	ğ	MD Anne A	cundol Cla	en Bur	nio				1 ☐ Yes 2√ No
4	288	je.	10e. Street and Number	. under Gre	II DUL	10f. Zip Code		10	Og. Citizen of Wha	
booke Medical	30.0	<u>=</u>	7355 Furnace	Branch Road H	East	2106	0		U.S.A	A •
1000	Ę	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. W	/as Decedent of Hispanio Yes, specify Cuban, Mex	c Origin? (Spe	ecify Yes or No-		American Indian, Vhite, etc.
စ္က ္ခ်ီ	or ft	J.	1 Never Married 2 Married	1 ☐ Yes 2 ☐ X No If Yes, Give		☐Yes XX No Spe			Specify:	
9500-	ural	d by	¾ Widowed 4 □ Divorced	Year or Dates:						Black
<u>ہ</u> 5	na collos	Completed	15. Decedent's (Specify only highest of	rade completed)	(Give k	ent's Usual Occupation rind of work done during I O NOT use retired)	most of worki	ng	16b. Kind of Busine	ess/Industry
<u> </u>	then the	E	Elementary/Secondary (0-12) 8th grade	College (1-4or 5+)	†	usewife			Home	
ם פ	Hyg other	BeC	17. Father's Name (First, Middle, La			18. M	lother's Name	(First, Middle, N	Maiden Sumame)	
Jand Hand	Aenta rked tic e	To B	Mike Porter			P	enny a	Staton		
ary E	and A		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street and Nu	umber or Rura	l Route Number,	City or Town, Star	e, Zip Code)
≥ ;	point. I ago the latter and Mental Hygiene. International street of the latter and 23s or 28s-1 show important: If item 27 is marked other than "natural", or thams 23s or 28s-1 show any injury or other traumatic avent, the Medical Examinat must be notified at once.		Forest Dupres	s-Neice	1516	Copeland	Boad	Cator	sville	Md 21228
ore	iter in the rest		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	1 ^	lace of Dispos	ition (Name of atory or other place)		ate 2	20c. Location - City	or Town, State
	tment of I		*4 ☐Donation 5 ☐ Other (Spec	wood Wood	odlawn	Cemetery	1/31,	/04	altimor	ce Co, Md
	Depar Impor eny in		21. Signature of Funeral Service Lic	nsee)	22. M	Name and Address of Fa	West			-5 (.33f5);
	102 4 4		23a. Part. Enter the disease, or co	Johnson h		300 Wabasi				
	N WA		shock, or heart failure. List on	y one cause on each line.	n. Do not ente					Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a Acul	e Y	lyo Card	har	Infa	rchan	4 days
	xaminer			Due to (or as a conseq	uence or):)				
w.	3	er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a conseq	uence of):					
patit	nd ransil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
of ou,	physician and the burial-transit	Ä	resulting in death) Last	Due to (or as a consequence	uence of):					
	hysic the bi	dlcai		d						
9	ding p	Me	IF FEMALE:	23c. If yes, outcome of pregna						1
מאַסם	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	I death 3 🗆 🛭	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
j	the ched	Physiclan/Me	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	eatii 5	Other (specify)				
The law requires that the death	been signed by the attending should be detached for use as	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the unc	derlying cause given in P	art I.	23e. Did tob	acco use contribut	e to the cause of death?
Records,	n sign		Conges	tive Hea	rtf	Calier		1 ☐ Ye	s 200 3 [Probably 4 Unknown
	s bee	lete	Diah	it. Me	11:4.	1 2		24a. Was an		autopsy findings available
ב ב	age 2	Completed				~		autopsy	prior deat	to completion of cause of
VIIGH	tifica tor. p	0	25. Was case referred to medical			26. P	lace of Death	(Check only one		7 B 10 10
> in	direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient			-	nce 6 Other (5	Specify)
0 4	fter th		27. Manner of Death 1 Avatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time ol Injury	28c. Injury at Work?			w injury occurred	
200	or: A	catio	2 Accident investigat	ha		M 1 Tes 2	2 □ No			
DIVISION	irect Sirect In by	Certification;	3 Suicide 6 Could not 4 Homicide determine		ome, farm, stre	et, factory, office	2	28f. Location (Str City or Town,	eet and Number of State)	Rural Route Number,
Jaje	ours a		29a, Certifier 1 Certifying	Physicians To the heat of my leas	wledge dass	populated at the time of the	a and else-	and due to the		
H	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only one)	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	tion and/or inve	estigation, in my opinion,	death occurre	ed at the time, da	te and place, and	due to the cause(s)
a the	Mithin To the	Me	29b. Signature and title of certifier	000		29c. License numb	per	29	d. Date signed (M	onth, Day, Year)
	2,-0		Muses	WO 60,	1-2	P-16	775	77	muary	22 2004
	3		30. Name and address of person wh	o completed cause of death (Item	n 23a) (Type, P		H SH	AH, MD	^1.	
_			Harbor Hos		3615	. Hanos	ver s	sta	Uhimor	CMI 21725
	Sta		31. Date liled (Month Ray Year) 8	2004 32. Rigistrar's Signa	iture	will i				

			1 - State Registrar	State of Ma	ryland /		artment of F tificate of			ene 2001	4 02052
	Physici	ian	1. Decedent's Name (First, Middle, Las GORDON WINFIEI	•	JR.				2. Date of Death Month	2 ^{Day} 2004 ^{Year}	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Death	01/2	4c. County of Dea	6:00a M
	Lxaiiii	101	19305 MIDDLETO	OWN ROAD			P	ARKTON		BALTIMO	RE
	Funeral Director			ex 7. Age ☐XM 2□F 68	(In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 02/14/	9. Bir 1935 MAR	thplace (State or Foreign ountry) YLAND
	land Dw		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation		·		10d. Inside City Limits
	Mary a-f sh	tor	MD BALTIN	IORE	PA	RKT	ON				1 ☐ Yes 2√☐ No
	death with the Maryland ms 23s or 28s-f show crival be notified at	Director	10e. Street and Number 19305 MIDDLETO	WN ROAD			10f. Zip Code 2112	n	10g	J. Citizen of What Co	ountry?
30	after or Ite	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 27 No		1	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2-0036	72 hours "natural", dical Exe		15. Decedent's Ed	Year or Dates:	16	a. Deced	ent's Usual Occup	ation	16	b. Kind of Business	/Industry
171	within 7 lene. than "n	Completed	(Specify only highest grave (0-12) 1 2	College (1-4or 5+	-)		kind of work done of NOT use retired PERVISO	during most of worki d) R	ng	STEEL	INDUSTRY
andz	be filed ital Hygi d other event.	To Be Co	17. Father's Name (First, Middle, Last) GORDON WINFIEI	D WEAVER				18. Mother's Name			TNDOOTKI
Mary	s 1 and 2 should by Health and Menta item 27 is marked other traumetic e	-	19a. Informant's Name/Relationship (1					and Number or Rura			
more,	Pages 1 al nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		cemet	erv. cren	sition (Name of natory or other place CREMAT	ion01/23		c. Location · City or HAMPSTEA	
Бапптог	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licen	ACO		1	Name and Address	ss of Facility HEN	IRY W. J	JENKINS J, MD. 2	& SONS CO.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or composition, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Securities list conditions if any, leading to immediate	b. Due to (or as a	consequence	of):	er the mode of dyin		r respiratory arrest		Approximate Interval Between Onset and Death
,00/0	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	c							
O. Box o	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal deat		Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ras, r	quires that in signed b	b	Part II. Other significant conditions of	entributing to death but	not resulting	in the un	derlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
a Recor	The larate has	Completed	<u>.</u>						24a. Was an autopsy performed	g? prior to death?	atopsy findings available completion of cause of
VICA	s certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	t 2 ER/O	lutnations	3□ DOA Othe	26. Place of Death		e 6 □Other (Spec	-4.1
5	ding Phys h. After this funeral di	 	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day)	28b.	Time of Injury	28c. Injury	at 2	8d. Describe how		ony)
IVISIOII	or Attending Physician: ter death. irector: After this certifici or by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined		y - At home, f		M 1 🗆 '	Yes 2 □No	8f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
2	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A c-mpletely filled in by the fu	edical Cer	(Chack only / 2 Madical Exam	vsician: To the best of piner: On the basis of e	examination a	e. death	occurred at the timestigation, in my or	ne date and place a	nd due to the cause d at the time, date	a(s) and manner as	stated to the cause(s)
	o the ithin 2 o the mplet	Med	29b. Signature and title of ceriffier	and manner state	ed.		29c. License			Date signed (Monti	
	FSFÓ		> 11/hell	/hun	11).		D	53907		Toneary	
,	5	į	30. Name and ada of per a wood	complet ca e o dea	ath (Item 23a)) (Туре, f	Print)	er Di	P.1	Que C	(m)
₹ 2	Sta		31. Date filed (Month, Day, Year)	32. Registrar'	's Signature	11	1	v Full	- 3111	VILLEY	
*	Registr	ar	JAN 2 8 2004	por part - and	13	pto	ander				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** George EVERETT WILSON JAN 12:20 AN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALT inole RdiCAL 7. Age (In yrs. last birthday)
Yrs. If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth Month, Day, JULY 21 5. Social Security Number 9. Birthplece (State or Foreign Funeral Months Days 215-16-0641 MARY LAND Director Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at MD 1 ☐Yes 2 ☐ No BACTIMORE Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 30th STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Mayes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc 2 Married BLACK Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 4 Divorced 3 ☐ Widowed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOTuse retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry end Mental Hygiene. College (1-4or 5+) STEEL FOREMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) LOUISE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1927 E. 30th STREET BALTIMORE, MARYLAND 21218 ALBERTA WILSON WIFE Depertment of Health Important: If Item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST CEMETERY 2.2.04 DWINGSMILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility VANCHIN C. GREENE FUNERAL HOME. 21. Signature of Funeral Service Licensee 4905 YORK RUAD BALTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificete be Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? eral Director: After this certificete filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 - No edical Certification: To Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 24 No 1. Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 2 Accident 1 ☐ Yes 2 ☐ No death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Reade St BALLi MARLES BEAMON JAN 28 32. Registrer's Signature 31. Date filed (Month. State 2004 Mener Registrar

			1 - State Amend Item 9 per Registrar	State of Maryland Fh,G827,01/28/0	4dhb <i>Cei</i>	tificate of	Death	Reg.	2001.	02054
,	Physicia /Medic		Decedent's Name (First, Middle, Last) Leola	М.		Willis		2. Date of Death Month January 5	Day 2004 Year	3. Time of Death 8:55a M
100	Examin		4a. Fecility Name (If not institution, give s Good Samaritan Num			•	r Location of Death .imore	0	4c. County of Death NA	
	Funeral Director		/10-03-09/2	7. Age (In yrs. la M 2∰ F 90	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp Cour	olace (State or Foreign otry) Unknown
	Maryland f show	or	Usuel Residence of Decedent 10a. State 10b. County Md. NA	10c. City.	Town or Lo	cation imore			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	ntry?
	death w	Funeral	6211 Birchwood Avo	12. Was Decedent Ever in U.S	S. 13. V	21214 Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Americ	an Indian,
9036	ours after ral, or ite	þ	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 27☐ No If Yes, Give Year or Dates:			Specify:	Hican, etc.)	Black, White, Specify: Bla	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural; or items 23e or 28e-f show any injury or other traumatic svent, the Medical Exaction from the Indified at Apple.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. l	dent's Usual Occup kind of work done DO NOT use retired Stitute T	during most of work d)	king	o. Kind of Business/Ind	
2 pc	e filed val Hygie other I	Be Co	5th grade 17. Father's Name (First, Middle, Last)			scitute i		e (First, Middle, Mai		ty Schools
ylaı	hould b d Menta narked natic s	To E	Joseph 19a. Informant's Name/Relationship (Ty)	Will		a Address (Street	Mazzie	ral Pauta Numbar C	Johnson	
_	alth and 2 sl		Ronald Willis	Son				Baltimore,		
timore,	Pages 1 a nent of He ant: If item ary or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ace of Dispo metery, cren butus	sition (Name of natory or other place Mem Pk.	1-30		Location - City or To	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service License	80		Name and Addre			ore, Md. E. North A	21202 V.
*	Physician		23a. Part1. Enter the disease, or composition of the composition of th	oftions that caused the death e cause on each line.	. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arrest,	lioy	Approximate Interval Between Onset and Death
	Medical Examiner bhysician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or as a consequence of	ence of:	eclas	aelier	eiden	1- :	3-H weeks
.O. Box 68760	The law requires that the death certificate ate has been signed by the attending physingge 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy	,		23d. Date of delive	ory Day Year
rds, P.	w requires that been signed I should be det	by	Part II. Other significant conditions cor	tributing to death but not resu	lting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the	4.6
Division of Vital Records,	sician: The law requ s certificate has been irector, page 2 should	Completed						24a. Was an autopsy performed	prior to cor death?	psy findings available appletion of cause of
Vita	sician certifii	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	t 3 DOA Oth		h (Check only one)	e 6 ☐Other (Specify	1
ion of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	\vdash	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injur Wor	y at	28d. Describe how		//
Divis	tal or Atte s after de: al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura tate)	I Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifler	Trepera	un	29c. Licens	3066	1 Ja	Date signed (Month, www. 27) - 2123	Day, Year)
_	2		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print) Ba	ltino	re- Ha	-2123	9.
2	Sta Registr	-	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure	acti i				

		-	For State	,	State o	f Marylar				ealth and I D <i>eath</i>					
			Registrar				Cei	runca	le oi l	Jeani	2. Date of Dea	Reg. No.	2004	3. Time of Deatl	h .
	Physicia		Decedent's Name (First, Midd.	e, Last)		, , ,					Month	Day	Year	10:264	
	/Medic	al	Maynard	F		MOIT		1 -			January	2,2	County of Death		
8	Examin	er	4a. Facility Name (If not institutio			mber)		46. City		Location of Deat	n		N/A	ı	
	*			169	ical	Center		0	er 1 Year	MORE If Under 24 Hrs.	8. Date of Birt		·	place (State or Fore	oian
	Funeral		5. Social Security Number	6. Sex 1⊠	M 2□F	7. Age (In yrs. 75	Yrs.	Months		Hours Min.	Jan. 1	Year)	29 Ma	ryland	argri
n.	Director		212-26-5711			75	113.	<u></u>	1		ban. I	,, = ,	23 110.	Ly Laria	
	pue 🖈	}	Usual Residence of Decedent 10a. State 10b. County	,		10c. Ci	ity, Town or Lo	ocation						10d. Inside City Lin	nits
	fary!	5	Maryland	Bali	imore	_				D	undalk			1 ☐ Yes 2 🔀	No
	the A	ect	10e. Street and Number	10010	211101			10f. Z	ip Code			10g. Citiz	en of What Cou	intry?	
	a or	급	7893 Charles	mont	Road					2122	2	Uı	nited S	tates	
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow he Medical Examinar must be notified at	Funeral Director	11. Marital Status			edent Ever in U	J.S. 13.	Was Dec	edent of H	ispanic Origin? (S	specify Yes or No	- 1	4. Race - Amer		
	iter d	ä	1 Never Married 2 Mar		Armed F	orces? 2 No ive Kora		,		n, Mexican, Puer	to Rican, etc.)		Black, White	, etc.	
36	Irs af	by	3 ☑ Widowed 4 ☐ Divorce		If Yes, G Year or [oates: Kore	ean	1 🔲 Yes	2☑ No	Specify:			Specify: W	hite	
21215-0036	thou sture		15. Decede	nt's Educa	ation		16a. Dece	dent's Us	ual Occup	ation	deina	16b. Kin	d of Business/l		
15	nin 77	ple	(Specify only higher Elementary/Secondary (0-12)	st grade		(1-4or 5+)	life.	DO NOT	use retired	during most of wo 1)	iking	Ba	ltimore	City	
212	with piene r the	Completed	12 Years		Conego		F	ire E	ight	er			re Depai		
	Hygid other	Bec	17. Father's Name (First, Middle	Last)						18. Mother's Na	me (First, Middle,	Maiden 3	Sumame)		
a	lid be lental ked c	To B	George Elmer	Woli	Ē					Emma 1	Rose Hof	fman			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than *natural', or items 23e or 28e-f show other traumatic event. The Medical Evantiest must be notified at	_	19a. Informant's Name/Relation	ship (Typ	e, Print)					and Number or R					
	1 and 2 Health a em 27 la		Maynard E. W	olf,	Jr.	(Son)	78	393 C	harle	esmont Ro					.2
Baltimore,	permit. Pages 1 au Department of Hea Important: If Item any injury or othe once.		20a. Method of Disposition	• - -		1	Place of Disponentery, cre	osition (N	ame of r other plac	ce)	Date	20c. Loc	cation - City or	Town, State	
Ë	Pages nent of I int: If It iry or o		iX⊒XBurial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (movali fron	Ogli	k Mawn	Ceme	etery	1/28/20	04	Ba.	ltimore	, Marylan	ıd
=	permit. Pa Departmen Important: any njury		21. Signulure of Funeral Service	Tichnse	1	1 h	2	2. Name	and Addre	ss of Facility Funeral	Home of	Dune	dalk. T	nc.	
ä	Deported Important		1 Most	1//	1	mell				Ave. D				1222	
	JF 5		23a. Part 1. Enter the disease, of shock, or heart failure. Lis	r complic	ations that	caused the dea	th. Do not en	ter the m	ode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between	1
	Pnysician		Immediate Cause (Final	t only on	1		D - 1		· •					Onset and Death	
78	/Medical		disease or condition resulting in death)	a.		(or as a conse		5	13					10011-01100	
	Examiner				12.1	ideal 1	1400 12	i Eu	no iz				•	Two Da	-نهت
) _p	ē	Sequentially list conditions, if any, leading to immediate) °	Due to	(or as a conse								Five Year	7
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	١.	C	andio.	My OP.	. they						Five Year	25
Ć	exec in an ial-tr	Exa	resulting in death) Last		Due to	(or as a conse	quence of):	-)						
8760,	certificate be executed diding physician and ise as the burial-transit	cai		U d.											
9	tificat 19 ph) as th	Completed by Physician/Medical													
Вох	eath certific attending pl	N/S	IF FEMALE: 23b. Was decedent pregnant	23	Sc. If yes, o	utcome of pregr	nancy	□ Ectonic	pregnancy	,		2	3d. Date of deli		
	death e atten ed for u	Cla	in the past 12 months?			gnant at time of		Other					Month	Day Year	
0	that the ed by the detache	hys	9 Unknown	-	9LI UNK	nown									
0.	res that the de igned by the a be detached t	γP	Part II. Other significant condi	tions con	tributing to	death but not re	sulting in the	underlyin	g cause giv	ren in Part I.				the cause of death	
ĕ	equires sen sign	ed	Chranic An	1 1	Bulh	cuncy	>				10	Yes 2	UM6 3□Pr	obably 4 Unkn	own
Vital Records,	> 0 ts	ojet	Congestive	He are +	- Fa	ilue					24a. Was		24b. Were au	topsy findings avail	iable of
Re	0 4 0	E	WA		clem						perfo	ormed?	death?	2 No	
ta	ician: Th certificate ector, pag	a	25. Was case referred to medic		2000	il Co	-			26. Place of De	ath (Check only				
5		To B	examiner? 1 ☐ Yes 2 ☑ No	Н	ospital:	Inpatient 2	☐ ER/Outpatie	ent 3	DOA Ott	ner: 4 Nursing	Home 5 Res	dence 6	S □ Other (Spec	cify)	
of		Ë	27. Manner of Death		28a, Date	e of Injury anth, Day Year)	28b. Time	of	28c. Injui	y at	28d. Describe	how injury	y occurred		
O	ding I th. : After s funer	tio	1 Natural 5 Pend	ling stigation	(MC	iiiii, Day 16ai)	Injury	М		Yes 2 □ No	10				
Division	Attending r death. ector: After by the fune	fice	3 Suicide 6 Coul	d not be mined	28e. Pla	ce of Injury - At ding, etc. (Spec	home, farm, s	treet, fac	ory, office		28f. Location (ral Route Number,	
ā	afor afte	Certification:	4 Homicide		Duii	uling, etc. (Spec	Sity)				.,,.,,.	,	'		
14	Hospital		29a. Certifier 1 Certify	ing Phys	Ician: To t	he best of my kr	nowledge, dea	th occurr	ed at the ti	me, date and plac	e, and due to the	cause(s)	and manner as	stated.	
1	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Chack only 2 Medic	aı Examir	er: On the and ma	basis of examir inner stated.	nation and/or i	nvestigat	ion, in my	opinion, death occ	urreu at the time,				
	To the within 2 To the comple	M	29b. Signature and title of certif	ier	1				29c, Licen:	se number			e signed (Monti	-	
			1 100	100	Val	1			357	105		Jan	10m 22	,2000	4
	41		30. Name and address of person	n who co									9		
	10,		Natalya W	Han	IC	4940 Ea	stern A	Ave.	Bal	timore,	Maryland	212	224		
	Si	ate	31. Date filed (Month, Day, Yea	7000	32.	Registrar's Sig	nature								
	Regis		JAN 60,	1004	1 34	Dan Ba	2 58.00	A 100 A							

DHMH 17 Rev 1/2001

ORIGINAL

			for State	State of Marylan	d / Depa		lealth and	Mental Hygi	ene 200	4 02056
	43		Registrar 1. Decedent's Name (First, Middle, Last)			rincate or i	Dealli	2. Date of Death	g. No.	* 107 time 147 tip? tip?
	Physici /Medio		Charles Willia	am Wetzelbe	rger,	Jr.		Month JANUAR	Day Year	3. Time of Death 3.4 03:38 141
À	Examin	er	4a. Facility Name (If not institution, give s Saint Joseph		ter	4b. City, Town, or	Location of Deat		4c. County of Dea	th Itimore
	Funeral Director			7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bin C 32 Ba	thplace (State or Foreign ountry)
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County MD Baltin		r, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23s or 28s-f show	Funeral Director	10e. Street and Number		oseda	10f. Zip Code	2.7		g. Citizen of Whal C	ountry?
	8 23s	rai	8321 Analee A			212			JSA	
036	filed within 72 hours after death with the Marylar Hygiene Hysiens than "natural", or Items 23a or 28a-1 show the than "natural", or Items 23a or 28a-1 show int, the Macilcal Examiner must be multified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☑ No Art If Yes, Give Year or Dates:	mv	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	Ispanic Origin? (S In, Mexican, Puer Specify:	to Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
ģ	72 ho	ted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation	dema 1	5b. Kind of Business	
121	within in the second of the se	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		kind of work done of DO NOT use retired efighte:			Baltimor Fire	e City Department
Maryland 21215-0036	S E D S	To Be C	17. Father's Name (First, Middle, Last) Charles Wetze	₩:FE lberger			18. Mother's Nar	ne (First, Middle, M. Ethel T	aiden Sumame)	<u> </u>
ary	and Men smarke	_	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	ng Address (Street a	and Number or Re	ural Route Number,	City or Town, State,	Zip Code)
	and 2 salth n 27 i		Filomena M. Wet:				Ave.,			land 21237
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	Computation State	emetery, crei	sition (Name of matory or other plac deemer	e) 1/2		oc. Location - City or altimore	Town, State , Maryland
Balti	permit. Page Department i Important: It any injury o		21. Signature of Funeral Service Ideense		22	2. Name and Addres		seph N.		Jr. FH MD 21224
7	5 A 28		23a. Part1. Enter the disease, or comples shock, or heart failure. List only on	cations that caused the death					· · · · · ·	Approximate Interval Belween
y =	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPSIS	-					Onset and Death
	Examiner			Due to (or as a consequ	ience of):					
die	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury	Due to (or as a consequ	ence of):					
,60,	te be executed ysician and e burial-transit	cal Exar	that initiated events resulting in death) Last	Due to (or as a consequ	ence of);					
			0							
XOM .	ne death certificate the attending phy ched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the pasl 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnat 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ο, σ	requires that the de- een signed by the a hould be detached f	d by Ph	Part II. Other significant conditions con PANCYTOPENIA	tributing to death but not resu	ilting in the u	nderlying cause give	en in Part I.	23e. Did toba	\ /	the cause of death?
Hecord	> 40 (0	iete	RENAL FAILURE					24a. Was an	24h Were a	utopsy findings available
	The la ate has page 2	Completed by	CHRONIC OBSTRUCT	VE PULMONARY	DISEA	SE		autopsy performe 1 Yes 2	prior to death? No 1 ☐ Yes	completion of cause of
Vital		o Be	25. Was case referred to medical examiner?	ospital:		Othe	r	ath (Check only one)		
	Phys	F 3	27. Manner of Death	ospital: 1 X npatient 2 1 8 28a. Date of Injury (Month, Day Year)	28b. Time of	I 3L DOA	4 Nursing H	lome 5 Residen		cify)
o	Attending F ir death. ector: After by the funer	tlor	1 Natural 5 Pending 2 Acciden investigation	(Month, Day Year)	Injury		:? /es 2 □ No			
many .	- a	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	edical C	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of my knowner: On the basis of examination and manner stated.	vledge, death ion and/or inv	n occurred at the time vestigation, in my op	e, date and place pinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	P. MD		29c. License	number	290	. Date signed (Mont	h, Day, Year)
	1.1		Timoly	JON 1111 N.		D241	234		1/23/0	4
1	ott		30. Name and address of person who con						,	,
	Sta	te.	31. Date filed (Month, Day, Year)	7671 051 32 Registrar's Signat	PIE DR	IVE TOW	SON, MAR	YLAND 2	204	
	Registr	_	JAN 2 8 200	32 Registrar's Signar	A. A.	3064				

John Wienecke 04-00 MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

0613	State of Maryland / Department / D	artment of Health and Mental F	lygiene Reg. No. 2004 02057
Physician /Medical	1. Decedent's Name (First, Middle, Last) John M. Wienecke	2. Date of Month Janu	Death 3. Time of Death
Examiner	A CONTRACTOR AND	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of	4c. County of Death NA Birth 9. Birthplace (State or Foreign
Funeral Director	216-92-3838	Months Days Hours Min. (Month, 10-8-	Birth Day, Year) -1963 9. Birthplace (State or Foreign Country) Maryland
Ba-f show	10a. State 10b. County 10c. City, Town or Lo	more	10d. Inside City Limits 1X Yes 2 □ No
sath with the saturation of th	10e. Street and Number 207 S. Highland Avenue	10f. Zip Code 21224	10g. Citizen of What Country? USA
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-1 show oreal Exeminer must be notified at etect by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ▼ No Specify:	No- 14. Race - American Indian, Black, White, etc. SpecifyWhite
within then then then then then then then the	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Die	dent's Usual Occupation a kind of work done during most of working DO NOT use retired) esel Mechanic	16b. Kind of Business/Industry M. Schaum Antoines Contracti
Maryland 2 The Should be filed that and Mental Hygis The marked other retraumatic event, II	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd Estelle C	dle, Maiden Sumame)
	19a. Informant's Name/Relationship (Type, Print) mother Estelle W. Wienecke 19b. Mailin 207	ng Address (Street and Number or Rural Route Nur S. Highland Ave.Bal	timore, MD 21224
Baltimore, Dermit. Pages 1 a Department of Her Importent: If them any injury or othe	'4 □Donation 5 □Other (Specify) Greenmo	ount 1/26/04	20c. Location - City or Town, State Baltimore, MD
Bal permi Depa Impo	23a. Part1. Enter the disease, or emplications that caused the death. Do not ent	2. Name and Address of Facility Joseph 263 S. Conkling St. ter the mode of dying, such as cardiac or respirator	Baltimore, MD 21224 varrest, Approximate
Physician /Medical	shock, or hear failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Arcotic intoxication Due to (or as a consequence of):	Į.	Interval Between Onset and Death
Examiner 5	Sequentially list conditions, and any leading to immediate cause. Enter Underlying Cause (Disease or injury		
8760, sate be executed bhysician and the burial-transit dical Examiner	that initiated events resulting in death) Last C: Due to (or as a consequence of):		
death certific death certific e attending p of for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
S, Se lighe be be be be be compared by	Part II. Other significant conditions contributing to death but not resulting in the b		d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
The lay		24a. W au pa	prior to completion of cause of death?
of Vita Physicien: this certific ral director,	examiner? Hospital: 1 Innation: 2 TFR/Outpation	26. Place of Death (Check online 3 DOA Other: 4 Nursing Home 5 Re	
Division of Vital To the Hospitel or Attending Physicien: 1 within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p. Medical Certification: To Be Co		of 28c. Injury at 28d. Describ Work? M 1 Yes 2 XNo Unknow.	ne how injury occurred
Div the Hospitel or A thin 24 hours after the Funeral Direc mpletely filled in by Medical Certif		Baltimo	ne cause(s) and manner as stated
To the Hosp within 24 hou To the Funel completely fil	(Check only and ittle of certifies) (Check only one) 25 Medical Examiner: On the basis of examination and/or in and manner stated.	29c. License number	e, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of teath (Item 23a) (Type,	O.C.M.E.	January 22, 2004
State	31. Date filed (Month, Day, Year) 32. Hegistran's Signature	l Penn Street, Baltimore	Maryland 21201
Registrar	JANA 8 /1914 Benevar le	Marker AL	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:02 PM 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Mar land niversite If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Y 8-21-56 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F 47 Yrs. Mď. 215-66-0472 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show other traumatic avant, the Medical Examiner must be notified at X□Yes 2□No Director Md NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Itams 23a 5701 Winthrope Ave. 21206 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumetic avant, the Medical Examination. I □Yes 2□No If Yes, Give X Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Varies 9th grade Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Young Delores 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delores Mercer Mother 5701 Winthrope Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1 - 30 - 04Zion Cem. Lansdowne, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. PDCB 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. March F.H. East 1101 E. North Ave. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) two weeks neumania Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 6876 IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month ò in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 Yes certificate 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 (Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3□ DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending s after death. 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral 1 🛪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1amwal9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State	of Marylan		artment of I rtificate of		Mental Hyo		04 02059
	Physicia	ın	Decedent's Name (First, Middle, SYLVIA	Last) M	ARNS	SPARGE	₹		2. Date of Dea Month January		3. Time of Death 4:48 AM
	/Medic Examin		4a. Facility Name (If not institution, Wicomico Nursing					or Location of Deat		4c. County of	f Death
o	Funeral Director			6. Sex 1 ☐ M 2 🛛 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs			9. Birthplace (State or Foreign Country) Kentucky
	death with the Maryland rms 23a or 28a-f show if must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicc	mico		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the	Director	10e. Street and Number 331A Cedar Dri	ve			10f. Zip Code 218	304		10g. Citizen of Wh USA	hat Country?
36 336	9 2 3	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 ☑ Morried	Armed F	2 X No		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No- rto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. white
215-00	thin 72 hou e natura Medical E	Completed	15, Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed) (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo d)	orking	16b. Kind of Bus	iness/Industry
Maryland 21215-0036	be filed with that Hygiens ad other the event, the	Be	12 17. Father's Name (First, Middle, I Jim Hensley	Last)		Hair	rdresser		me (First, Middle,		y Salon
aryl	12 should h and Mer 7 is marke traumatic	은	19a. Informant's Name/Relational Sheila Shrieves		r			t and Number or F	Carter Poute Number North M		ach, SC 29582
ン リ とレバな Baltimore, M	ages 1 and int of Healt t: If Item 2 y or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 □Removal from	20b.	Place of Disponentery, cre	osition (Name of matory or other pla		Date		City or Town, State
³ γ Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service		(FIP	1	Name and Addr	Funeral	and the same of th	fessiona.	l Association
8760.	the Hospitel or Attending Physician: The law requires that the death certificate be executed by a Second of Second o	dicai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	a. Due to	o (or as a consection of cor as a consection of correct o	quence of):	CANC	ΕR			Interval Between Onset and Death
P.O. Box 68760.	that the death certific od by the attending p detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No 9 Unknown	1 ☐ Live	utcome of pregn birth 2 Fet gnant at time of nown	al death 3	□Ectopic pregnand □ Other (specify)	су		23d. Date Mon	of delivery th Day Year
	requires that the been signed by should be detact	ed by Ph	Part II. Other significant condition	ons contributing to	death but not re	sulting in the	underlying cause g	iven in Part I.	1		bute to the cause of death? 3 Probably 4 Unknown
Division of Vital Becords.	The law requate has been page 2 should	Completed	HYPEG	TENSIO	A				24a. Was autor perfo 1 Yes	rmed? de	Vere autopsy findings available for to completion of cause of eath?
f Vita	ding Physician: 1.7. After this certifical funeral director. p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2] ER/Outpatie	int 3 DOA	then: 4 Nursing	eath (Check only only only only only only only only		r (Specify)
sion o	Attending Ph death. ctor: After th y the funeral		27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	gation	e of Injury onth, Day Year)	28b. Time Injury	M 1[Yes 2 No		how injury occurre	
, ivi	To the Hospitel or Attent within 24 hours after dest To the Funeral Directors completely filled in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	sined 286. Plat buil	ding, etc. (Spec	eify)	treet, factory, office		City or To	wn, State)	or or Rural Route Number,
,3	the Hosp in 24 hou the Fune	edical	(Check only 2 Medical one)	and ma			nvestigation, in my	opinion, death occ		date and place, a	nd due to the cause(s)
	To To To Com	Σ	29b. Signature and title of certifie	lust	1	D	-	060513		1/7/C	(Month, Day, Year)
10D	Q			rayappa M	.D. 6	14 Easte		ive Salist	oury MD 218	04	
0	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		Registrar's Sign	nature &	Spark	h			

		For State Registrar	State of Maryland	d / Departme <i>Certifica</i>					2004	02	060
Physici	an	1. Decedent's Name (First, Middle, Last)	Bathor	`			2. Date of Dea Month	Day	Year 2004	3. Time o	
/Medic Examin		4a. Facility Name (If not institution, give str THE JCH NS HOPK 5. Social Security Number 6. Sex		AL BAL		Inder 24 Hrs.	8. Date of Birt (Month, Da) OCT 22	h Year)	9. Birth		
Director	_	213-48-0349 Usual Residence of Decedent 10a. State 10b. County		, Town or Location			001 22	, 1332	, IIdi	10d. Inside C	City Limits
with the Ma Sa or 28e-f	I Directo	Maryland Cecil 10e. Street and Number 26 Cypress Drive	Noi		ip Code				of What Cou		
ite; INIAI yidalid ZIZIOCOOO s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28e-f ahow other traumatic event, the Madical Examinations to be notified at	by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates:	If Yes, sp	ecify Cuban, M	nic Origin? (Spe exican, Puerto F pecify:	cify Yes or No Rican, etc.)		Race - Amer Black, White ecify: Wh		
ithin 72 hourship	Completed b	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation	life. DO NOT	rork done during use retired)	g most of workir	ng		of Business/li	ndustry	
in yearloo Z. I.Z. Induction of the within the Mental Hygiene. Warked other then marked owent, I.c. Mental Count, I.c. Mental C	Be	12 17. Father's Name (First, Middle, Last)	2. thor	Microfil	18.	essor Mother's Name Nancy Bo			king mame)		
d d d d d d d d d d d d d d d d d d d	To	Lawrence Charles F 19a. Informant's Name/Relationship (Type Katherine B. Fanta:	e, Print)	19b. Mailing Addre	ss (Street and I	Number or Rura	Route Numbe				
Defilingle, in permit. Pages 1 and 2 Department of Health Importent: if item 27 i any injury or other tra once.		20a. Method of Disposition 1 🛱 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State Imi	lace of Disposition (Nemetery, crematory of Naculate	ame of other place)	Janua	ry 20,	20c. Locat	ion - City or 1	Town, State	land
permit. Pages Department of Importent: If is any injury or once.		21. Signature of Funeral Service Licensee	- tella	Hicks 103 W	Stockt	or Funer con Stre	et, El	kton,	Maryl	and 21	
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Finat disease or condition resulting in death)	Pontine	Hemorrh	age			niest,		Interval Be Onset and	etween
be executed cian and purial-transit	dical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	vence of):						44 4	jears
The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 Ectopic				230	d. Date of deli Month	very Day	Year
wrequires that the bear signed by should be detact	b	Part II. Other significant conditions conf	tributing to death but not res	ulting in the underlying	g cause given in	Part I.			contribute to		
	Completed						24a. Was auto perfo 1 🗆 Yes		24b. Were au prior to death?	completion of	s available cause of
n OI ng Phy fter this ineral di	To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 Inspection 2 Inspecti	ER/Outpatient 3 28b. Time of Injury	Other: 28c. Injury at Work?	Place of Death University Hotel		dence 6		afy)	
UIVISION OI To the Hospitel or Attending Phys within 24 hours affer death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of tnjury - At he building, etc. (Specif	ome, farm, street, fact	4		28f. Location (City or To		lumber or Ru	ral Route Nu	mber,
he Hospite n 24 hours he Funerel pietely fille	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examination and manner stated.	tion and/or investigati	on, in my opinio	on, death occurr	and due to the ed at the time,	date and pl	ace, and due	to the cause	
To the To the Comp	M	7/70.	d Decter		RES-				nuary,		
C		30. Name and address of person who co Tames Costle, M. 31. Date filed, (Month, Day, Year)	mpleted cause of death (Iter D: Department 32. Registrar's Signa	t of Neurola	94, 600	North Wel	FeSt, Bal	Himore	, MD, 2	1287	
Regis	tate trar	31. Date filed (Month, Day, Year)	Bours 18								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

					William -	ina.			of Death	IIIO IIIO		No. 2 ()	n.	02061
	Dhysiair		1. Decedent's Nam	e (First, Middle, L	ast)						ate of Deeth			3. Time of Death
	Physicia /Medic			T. Devl						1 _		_{Dey} 2004	Year	8:55 A.M.
	Examin	er	4a Fecility Neme (/		ive street and nun	nber)				wn, or Location	of Death	4c. County		
			Manor Ca		0	7 4 "		If I Indox 1 V		hesda			gomer	
	Funeral Director		5. Sociel Security N 197-14-2 Usuel Residence of	2218	Sex 1□M 2 X F	7. Age (In yrs. 87	Yrs.	Months D	ear If Under a	Min. 8. D. 6-	ate of Birth fonth, Day, Ye -13-191	ar) 6		ace (Stete or Foreign ry) ylvania
	aryland ahow	1	10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation					10	d. Inside City Limits
	the Maryls 28a-f aho ocutf ed at	ģ	Md.	Montgor	nery	Ве	thesda	ı						1 ∏ Yes 2 □ No
	ith the M or 28a-f	<u>§</u>	10e. Street and Nur			1		10f. Zip Co	de		10g.	Citizen of \	What Count	ry?
	123a Vi	Funeral Director	6530 Den	nocracy I	Blvd.			20	817		τ	JSA		
		Ē	11. Merital Status		12. Was Dece Armed For 12 Yes	dent Ever in U	,S. 13.	Was Decedent	of Hispanic Orig Cuban, Mexican,	gin? (Specify Y	es or No-		e - America	
Maryland 21215-0020	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-f ahow he Madical Examiner must be exitted at	2	1 ☐ Never Merri 3X Widowed	ied 2 Married 4 Divorced	14 Yes If Yes, Give Yeer or Da	2□No ∍ WWII tes: WWII			No Specify:		, 5.6.,	Specify		
5-	nafu Jesu	Completed	(Spec	15. Decedent's E cify onfy highest gi	ducation ade completed)		16a. Dece (Give	dent's Usual O kind of work d	ccupation lone during most etired)	of working	16b	Kind of B	usiness/Indu	ıstry
12	withir bne.	E .	Elementery/Seco	ndary (0-12)	College (1	4or 5+)			-		P		Calar	_
9	12 I I I	ပ္	17. Fether's Neme ((First, Middle, Las	t)		OWII/O	perato		r's Name (First	, Middle, Maid		Salor	1
<u>la</u> n		To Be	E.P. Mo	organ The	lan					Cabot		on coman	,0,	
ary	d 2 should th and Mar 7 Is marke traumetic	-	19a. Informant's Na				19b. Mailir	ng Address (St	treet and Number	r or Rural Rou	te Number, Cit	y or Town,	State, Zip (Code)
	= ~ ·		Jan V. Va	an Horn,	Son				oaf Dr.					,
ore			20a. Method of Disp		70	20b. F	Place of Dispo	sition (Name o	of r place)	Dat	e 20c.	Location -	City or Tow	m, State
Baltlmore,	A # 5 W			☐ Cremation 3 [5 ☐ Other (Speci		iale			rdes Cem	ı. 1-9	-04 B	lades	, De.	
3alt	permit. P Depertme Importan any Injur phos.		21. Signature of Fu	neral Service Lice	nsee				ddress of Facility Funeral					
ш	205 2 2	1	C	Tewell	N				St. Lau			56		
			23a. Pert1. Enter the shock, or hear	ne diseese, or control ailure. List only	pications that ca	used the deat	h. Do not ent	er the mode of	dying, such as o	ardiac or resp	iralory arrest,		1	Approximate nterval Between
	Physician						D						(Onset and Death
	/Medical Examiner		Immediate Cause (I disease or condition resulting in death)	rinai n	θ		neur	40419					1	days
		6				Due to (d	or as a conseq	uence of):					1	,
	ficeta be exacuted physicien end se the buriel-transit	Examiner	Cognostially list con	aditions C	b	Due to la	or as a conseq	uonco of):				·		
ó	death certificeta be execut e attending physicien end of for use es the bunel-trar	Ě	Sequentially list cor if eny, leading to im cause. Enter Under Cause (Diseese or i	mediate rlying		000 10 (0	as a conseq	delice oi).					1	
68760,	eta be nysici he bu	0 1	Cause (Diseese or i that initieted events resulting in death) L		C	Due to (o	r as a conseq	uence of):						
8	E 0	2	. oouting in oouting E										i	
Box	ath ce	an Z			d								!	
	the a	ysic	Part II. Other signifi	cant conditions	contributing to dea	th but not res	ulting in the ur	nderlying cause	given in Part I.	2	3b. Dld tobac	co use cor	tribute to t	he cause of death?
P.0	that the by datac	£									1 🗆 Yes	20 No	3 Proba	bly 4 Unknown
Division of VItal Records,	w requiras that the death cer been signed by the attendin should be datached for use	Completed by Physician									la. Wes an au	loneu	24h Were	e eutopsy findings
00	w req	e e								_ '	performed	орзу	avail	able prior to pletion of cause
Re	nysician: The lew his certificate has t i director, pege 2 s	ᇍ										-A-	of de	
tal	Ifficat tor, po		25. Wes case referr	ed to medical					26 Place	of Death (Chec		2ATNo	10	Yes 2□ No
>	Physician: this certific ral director,	10 1	examiner?		Hospital: 1 ☐ in	patient 2 🗆	ER/Outpatien	t 3□ DOA			☐ Residence	6 □Othe	or (Specify)	
0	ng Phya ter this naral di	چ	27. Menner of Death	5 Pending	28a. Date of		28b. Time of Injury		njury at Work?		escribe how in			
Si	Attanding or death. actor: After by the funa	뼕	2 Accident	investigatio	n	, buy . ou.,	injuly		1 Yes 2 N	0				
Ž	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place o	of injury - At ho g, etc. (Specify	ome, farm, stre	et, factory, off	ice	28f. Lo Cit	cation (Street	and Numbe	er or Rural F	Route Number,
Ω	urs at ral D	5		X -			1010-1							
	To the Mospital or Attanding Phy within 24 hours after death. To the Funeral Director: After thi complataly filled in by the funaral	edical	29a. Certifier (Check only one)	1 Scertifying Ph 2 Medical Exar	ysician: To the b niner: On the bas and manne	is of examinal	wledge, death tion and/or inv	occurred at the estigation, in n	e time, date and ny opinion, death	place, and due occurred at the	e to the cause ne time, date a	s) and mai nd place, a	nner as stat and due to th	ed. ne cause(s)
	Vithin Fo the		29b. Signature and t	itle of certifier	//			29c. Lic	ense number	,	29d. D	ate signed	(Month, Da	ıy, Year)
				UA MA	#	Physici	ichy		D0055	694	_	Tarus	ry 61	2004
D	Ò	3	30. Name and eddre			of death (Item	23a) (Type, F	Print)	Me Rel					
	State	e i	31. Dete filed (Month			jstrer's Signa	ture	Soon	, , , ,		1 8			
	Registra		J	JAN 082	2004	repeva	19	Spar	Ks					

DHMH 16 Rev 6/95

			For State Registrar		State o	f Mary		epartmer Certificat				lental Hyg	giene Reg. No. 2	004	02062
	Physicia	an	Decedent's Name (First) MILBERT))		ORD					2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not in:				ORD	4b City	Town or	Location (of Death	Januar		2004 nty of Death	10810 "
	Examin	er	25 a lul ul b	al LEISH	VA MA	0/191	CENT	· Lab	TOWN, OF		13 60	ns	*	1,000	
2	Funeral		5. Social Security Number	6. Se	x M 2□F		yrs. last birth	day) If Unde	1 Year Days	If Under Hours	24 Hrs.	8. Date of Birt (Month, Da	h y, Year)	9. Birth	place (State or Foreign intry)
	Director		217-30-9900		MM 2□F	70) Yı	s.				June l	8,1933	Ma	rýland
	land		Usuat Residence of Deced 10a. State 10b. (County		100	c. City, Town	or Location							10d. tnside City Limits
	Mary a-f sh	tor	Maryland	Wicom	ico		Pitts	ville							1 Yes 2 No
	ith the Marylan or 28a-f show	Direc	10e. Street and Number						Code	_			10g. Citizen		intry?
	ath w	rail	34900 Popla	r Neck	Rd 12. Was Deci	adost Ever	in II S		21850		igin? (Sne	acify Vac or No.	USA	Race - Amer	ican Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Di		Armed Fo 1 ⊠Yes	rces?		If Yes, spe		Specify:		ecify Yes or No Rican, etc.)	Spe	Stack, White	
5-0	72 hc	eted	15. Do (Specify only	ecedent's Edi highest grad	ucation de completed)		(ecedent's Usu Give kind of wo	ork done d	during mos	st of worki	ing	16b. Kind o	Business/I	ndustry
121	within ene. than	Completed	Elementary/Secondary	0-12)	College (1-4or 5+)		ife. DO NOT L Lerk	ise retired	")			Groce	ry St	ore
Maryland 21215-0036	12 should be filed within ' h and Mental Hygiene. 7 is marked other than " traumatic event, the Meg	To Be Co	17. Father's Name (First, I	_			, 02				ors Name	e (First, Middle, d McDa		ame)	
lan	2 sho and h is ma		19a. Informant's Name/Re					•				al Route Numbe			
	1 and Health Irm 27 ther tr		Phyllis Ann		wife	2						., Pitt	SVIIIe 20c. Locatio		
Ö	ages nt of th t: If ite		1 XBurial 2 ☐ Cren	nation 3 🗆		State I		isposition (Na crematory or ille Ce				0/04		sville	
Baltimore,	nit. P partme ortan injur		* 4 □ Donation 5 □ C 21. Signature of Funeral S				11000								ssociation
ä	permi Depa Impo any ii		> Keety	Che	nerel	CFS	P	501 S	now 1	Hill	Rd.,	Salisb	ury, M	D 218	04
0	Physician	6 1	23a. Part1. Enter the dise shock, or heart failui tmmediate Cause (Final disease or condition	ase, or comp e. List only o	dications that cone cause on e	caused the each tine.	death. Do no	t enter the mo	de of dyin	g, such as	cardiac d	or respiratory ar	rest,		Approximate Interval Between Onset and Death
8	/Medical Examiner		resulting in death)		Due to	(or as a co	nsequence of):							
9	Lxammer	-	Sequentially list condition	s,	b. Due to	(or as a co	nsequence of):		_					
m	uted d ansit	cal Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	1	C									1	
1 0°	te be executed ysician and te burial-transit	Еха	resulting in death) Last	Ť	Due to	(or as a co	nsequence of):					-		
9760	9 %				d			.							
Feld. O. Box 6	Attending Physician: The law requires that the death certifica rideath. octor: Atler this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 Yes 2 No 9 Unknown	iant		oirth 2 🗀	Fetat death	3□Ectopic p 5 □ Other (s						Date of deliment	very Day Year
rds, P.	quires that the signed by ald be detacted	d by Ph	Part II. Other significant of	conditions of	AND 12	eath but no	ot resulting in	the underlying	cause giv	en in Part I	1.	23e. Did to	_		the cause of death?
- 00	aw requii ts been s 2 should	Completed	DIABE	755	MEL	LIM	U,S					24a. Was		b. Were au	opsy findings available ompletion of cause of
S A	The late has page	Com	RENAL	In	JUH	FC	EEN	4				perfo	rmed? 2 No	death? 1 ☐ Yes	2□ No
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to examiner?		Hospital:			11 Solar	Oth	0.5		h (Check only o			
of	Phys rthis raldir	2	1 Yes 20 No		1 🗆	Inpatient of tnjury oth, Day Ye		ne of	OA Out 28c. Injun Wor	4 🗆 IN		me 5 X Resident			ify)
<u>o</u>	nding Ph nth. r: After th e funeral	ation	1 Natural 5 ☐ 2 ☐ Accident	Pending investigation		ith, Day Ye	ar) Ini	ury M		k? Yes 2□	No				
) Division of Vital	in Signal	Certification:	3 Suicide 6 Homicide	Could not be determined	208. Place	of Injury - ing, etc. (S	At home, farr Specify)	n, street, facto	ry, office			28f. Location (3 City or Tox		mber or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir. completely lifted in I	edicai	29a. Certifier 1X C (Check only 2 N	Certifying Phy ledical Exam	niner: On the b	e best of m easis of exa	amination and	death occurred for investigation	d at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of	certifier	and mar	mer stated.		29	c. Licens	e number			29d. Date siç	yied (Month	: Day, Year)
	⊢ > ⊢ ŏ		· 16.6	Luz	re	M	20	K	00	146	080)	01/	06/	04
1,7	0		30. Name and address of	11		se of death	(Item 23a) (T					SAL	15641	4/	m5
U	Sta	ite	31. Date filed (Month, Da	0.7	-	Registrar's		1.	/					1	
	Regist		1/1	NOR	2004	Sene	ran	D 1	pour	Es					

Margaret Gibson
Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Flease	State of Maryland				-		_	
		1 - For State Registrar	State of Maryland		rtificate of			Reg. No.	-200L	02063
¥	w	Decedent's Name (First, Middle, Last	it)				2. Date of Dea Month			3. Time of Death
Physicia /Medic Examin	al	Margaret Mary	Gibson		4b. City, Town, o	r Location of Deat	Jan. 1	14,	2004 County of Death	9:30A M
Examin	er	Civista Medica			La P1	ata			Charles	3
Funeral Director		092-26-2663	ex 7. Age (In yrs. las □ M 2対F 89	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Oay	3	9 Righ	place (State or Foreign intry) V York
yland		Usuat Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	ocation					10d. Inside City Limits
death with the Maryland ms 23a or 28a-f ahow rmust be millied at	Director	MD Charles 10e. Street and Number	Lal	Plat	a 10f. Zip Code			10g. Citi	izen of What Cou	1X Yes 2 □ No untry?
3a or		l Hickory Lane	Apt 110		20646			U.	S.A.	
death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-		14. Race - Ameri Black, White	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Insperment of Health and Mental Hygiene. Inspertment of Health and Mental Hygiene. Inspertment of Health and Mental Hygiene. and insperment if the Z71 is marked other than "natural", or Itama 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be multised at ODEs.	by	1 🔯 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No		to ribari, story		Canaita	hite
n 72 hou	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Ki	ind of Business/fr	ndustry
yethi jene. r then	ошр	Elementary/Secondary (0-12)	College (1-4or 5+) 7+	N-	urse			Reg	gistere	d Nurse
be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,			
d Mer mark	7	George William 19a. Informant's Name/Relationship (19b. Maili	ng Address (Street		e Roggy			ip Code)
nd 2 s lith an 27 is r trau		Amy Gibson/ Nie	di)		Box 33				20617	
s 1 ar		20a. Method of Disposition	20b Plac	ce of Dispo	sition (Name of		Date		cation - City or T	own, State
Page nent c ant: If ury or		1 ☐ Burial 2 【XCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	() Brin	nstie mato	majory or other pla eId-Echo ry	ols 1/1				Hall, MD
permit. Departr Imports any inj		21. Signature of Funeral Service Licer		2	2. Name and Addre	ss of Facility Ar				eral Home
00540	-	23a. Part1. Enter the disease, or com	plications that caused the death		.O. Box				aryland	Approximate
		shock, or heart failure. List only	one cause on each line.	-					CT	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. HTHEKO		ROTIC	HEAK	1 DES	七月	25	
Examiner		Sequentially list conditions,	b							
sit ad	Examiner	it any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to [or as a consequent	nce of:						
be executed ician and burial-transit	xarr	that initiated events resulting in death) Last	c Due to (or as a consequent	nce of):						
e be execu sician and burial-tra	calE		d							
tificating phy as the	Medi	15 551115								
The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1 Live birth 2 Fetal de	eath 3	□Ectopic pregnanc □ Other (specify)	у		4	23d. Date of deliv Month	very Day Year
t the de by the a	ysic	1 Yes 2 No 9 Unknown	4□Pregnant at time of deal 9□ Unknown	51	_ Other (specify) _					
s that	by Pr	Part II. Other significant conditions of	-	ing in the u	inderlying cause give	ven in Part I.	23e. Did to	bacco u	use contribute to	the cause of death?
w requires that s been signed t	ted t	PNEUMO					1 🗆 Y	es 2	No 3□ Pro	obabiy 4 Unknown
law range bear bear bear bear bear bear bear bea	Completed	MELANO					24a. Was a autop	sy	24b. Were aut prior to co death?	topsy findings available ompletion of cause of
		HYPERTE	NSTON.				1 Tes	med? 2 No	1 ☐ Yes	2 No
	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 EF	D/Outpotio	nt 3 DOA Ott	200	ath <i>(Check only oi</i> Home 5□ Resid		6 Other (See	i6d)
g Physer this	n: To	27. Manner of Death		8b. Time o		ry at	28d. Describe h			19)
andin path. pr: Aft	atio	1 Natural 5 Pending investigatio	n			Yes 2 □ No				
after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		e, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and m, State	nd Number or Rui p)	ral Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my knowled niner: On the basis of examination	edge, deal	th occurred at the travestigation, in my o	me, date and plac opinion, death occ	e, and due to the durred at the time, d	cause(s) date and	and manner as d place, and due	stated. to the cause(s)
o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Dat	te signed (Month	Day, Year)
F 3 F ŏ		> Vi Anm	angardh	4	D-26	5064		0	1-14-	2004
		30. Name and address of person who	completed cause of death (Item 2	23a) (Type						•
362		Vidyasagar Anm	angandla, MD	Р.	O. Box	282 Cha	rlotte	Hal	1, MD	20622
Sta	ite	31. Date filed (Month, Day, Year)	32. Redistrar's Signatur	K	Procedi 1					

			Please	Type or Print					•	
			1 - For State Registrar	State of Ma	•	partment of I ertificate of			jiene •g. №.2 0 () L	02061
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		3. Time of Death
	/Media	al	Joseph Lee Hoop 4a. Fecility Name (If not institution, giv			4h Cihi Town	or Location of Deet	JANLIARI	4c. County of Dee	0035 M
	Examir	ier	PENINSULA REGIONAL		WHEN		1/1sbuld		Hicom	
	Funeral Director		5. Social Security Number 6. S 218-34-9309		(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey 7-7-193	Year) 9. Bir	thplace (State or Foreign ountry) Md •
	land ow		Usuet Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Man	ctor	Md. Wicomi	co	Hebron					1X1 Yes 2 □ No
	with the or 28	Funeral Director	10e. Street and Number 209 W. CHurch St	#22		10f. Zip Code 21830		1	Og. Citizen of What Co USA	ountry?
	death ms 23	neral	11. Marital Status	12. Was Decedent Ev	ver in U.S. 1	3. Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Am	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show amy riqury or other traumatic event. The Medical Examinar must be notified at ance.	by	XX Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Puerl	o Rican, etc.)	Specify: Wh	te, etc. nite
15-(n 72 h "natu edica	lete	15. Decedent's E (Specify only highest gr		16a. De	cedent's Usual Occup ive kind of work done s. DO NOT use retire	oation during most of wor	rking	16b. Kind of Business	/Industry
212	d withingiene.	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	stodian	9		High School	01
nd	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last					ne (First, Middle, I		
Maryland	hould d Men marke maric	မှ	William Allen Ho 19a. Informant's Name/Relationship (19h Ms	ailing Address (Street		uitt Hoop	City or Town, State,	Zin Code)
<u>⊠</u>	alth an 27 is or traus		Patricia Hooper-	** '	1				orings, Md	
altimore,	of Hear of Hear or othe		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □	Removal from State	cemetery, c	sposition (Name of rematory or other pla			20c. Location - City or	_
Ę	t. Pag rtment rtant: njury c	. 9	*4 ☐ Donation 5 ☐ Other (Special	y)	Mardela	Memorial		1-2004 N	Mardela Sp	rings, Md.
Ba	Depa Impo any ic	0	21. Signature of Funeral Service Licer	1500		22. Name and Addre	ral Home		100/0	
الم	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	he death. Do not d	uma	ng, such as cardiac	or respiratory arm	Fail Fail	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a	consequence of):	COPY				
	cuted nd ransit	amlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
68760,	ite be exe iysician ar ne burial-t	ical Exa	resulting in death) Last	Due to (or as a	consequence of):					
P.O. Box 68	The law requires that the death certificate be execute has been signed by the attending physician and agge 2 should be detached for use as the burial-trains.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc; 5 □ Other (specify) _	/		23d. Date of de Month	livery Day Year
	s that med b	y Pt	Part II. Dther significant conditions	ontributing to death but	not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ord	require sen sig			- Chy	Je Ken	N Wight		1 🗆 Ye	s 2 No 3 P	obably 4 Unknown
3ec	has b	Completed		() (alex	Cer office	~ Os -	0-	24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
ta	ilcian: Th certificate rector, pag	e Co	25. Was case referred to medical	CSLIVE	.) wy	104 00 74	26 Place of Dog	1 ☐ Yes 3	No 1 ☐ Yes	2 No
Ž	Physicia this cert al direct	To B	examiner? 1 🗆 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpat	ient 3 DOA Oth	ac		ince 6 Other (Spe	city)
o uc	ling Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	y Wor		28d. Describe ho	w injury occurred	
Division of Vital Records,	or Attending Physician: after death. Director: After this certifics in by the funeral director.	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, farm, (Specify)	M 1 □ street, factory, office	Yes 2 □No	28f. Location (St. City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital or Attending Physician: The within 24 brous after dash. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) Certifying Physics (Check only one)	ysician: To the best of niner: On the basis of e and manner state	xamination and/or	eath occurred at the tir investigation, in my o	me, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	. 0		29c. Licens		_ 29	9d. Date signed (Mont	h, Day, Year)
			· c-lar	1 v.V		14	725		1/8/	04
5)		30. Name and address of person who	completed cause of dea てんし	ath (Item 23a) (Typ	ne, Print)	= Dezin	1 100	- (3)	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 2	2004 32. Registrar	's Signature	4 Spour	h		76 1	

		1 - For State Registrar	J	1010 01 111	ar y tarra	•	icate of		•		nnu	020
		1. Decedent's Name (First, Mid	tle, Last)						2. Date of De	ath	007	3. Time of Dea
Physicia		JAMES	A	HA	VES	51	२		Month			0804
/Medic Examin		4a. Facility Name (If not instituti	on, give stre	et and number)	/	4b	. City, Town, o	or Location of Deat	h	2. Date of Death Month Month Day Year 2004 4c. County of Death Month, Day, Year) 10g. Citizen of What Country? 10g. Citizen of Death 10g. Citizen of What Country? 10g. Citizen of Death 10g. Citizen of What Country? 10g. Citizen of What Country? 10g. Citizen of Death 10g. Ci		
		PENINSYLA REG	INM	16011	AL C	SHER		SAL/Shun	1		>	
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. las	t birthday) If	Under 1 Year		8. Date of Bir			
Director		138-16-3155	128.W	2 🗆 F	3-2	Yrs.	onths Days	Hours Min.	8-11		Coui	J. J.
		Usual Residence of Decedent							2. Date of Death Month Day Year 2000 A 2000			
er, or items 23e or 28e-f show Exemirer must be natified at		10a. State 10b. Coun	•		10c. City,	Town or Location	on				1	0d. Inside City Li
e a	cto	MD, W	1COM	100	S	ALISE	DRY					Yes 2
or 28	Funeral Director	10e. Street and Number				1	Of. Zip Code			10g. Citizer	of What Cou	ntry?
238	<u>=</u>	518 WINDE	R S	Ti			2	1801			USA	
SE 1	ner	11. Marital Status	12.	Was Decedent Armed Forces?	Ever in U.S.	13. Was	Decedent of I	Hispanic Origin? (S	pecify Yes or No	14.		
or Ite	F	1 Never Married 2 Ma	rried	1 XYes 2 ☐ I	No				o Alcan, etc.)			etc.
F. E.	by	3 ⊠Widowed 4 □ Divorce	rd .	Year or Dates:	ARMY	1 14	Yes 210 No	Specify:		Sp	pecify: B	LACK
	Completed	15. Decede	nt's Education	on on		16a. Decedent	s Usual Occup	pation	de la c	16b. Kind	of Business/In	dustry
E S	ple	(Specify only high Elementary/Secondary (0-12)		College (1-4or 5	5+)			during most of world)	King	-) _ ^ \	
th a	E O			00	,	SE	CURIT	У		1	ERDU	E
of Health and Mental Hygiene. Item 27 is marked other than "nature other traumatic event, the Medical	e C	17. Father's Name (First, Middle						18. Mother's Nar	ne (First, Middle,	Maiden Su	mame)	
Menta arked atic ev	To Be	JAMES A	HA	NES	SR.			GLAD	VS VA	UGH	In) H	AVFS
nd Menta marked imatic e		19a. Informant's Name/Relation				19b. Mailing A	idress (Street	and Number or Ru	ral Route Numbe	or, City or To	own, State, Zip	Code)
Ith a	1	FAVIF FIEL	150	NEICE		inadi	本の一					2300
f Health item 27 other tr		20a. Method of Disposition	7CA~	, /0 0 100	20b. Plac	e of Disposition	(Name of		Date	20c. Locat	ion - City or To	wn, State
£ ± 6	1	1Æ Burial 2 ☐ Cremation		oval from State	cem	etery, cremato	y or other pla	CB)	1	11.0		111/
Department o Important: If any injury or once:		'4 □Denation 5 □ Other			IND	VA C	EMET.	ARY 1//	5/04	HUR	LOCK	MID
Depar Impor any in	1	21. Signature of Funeral Service	a Licensee).		22. Na	me and Addre	ess of Facility	ENNIE	SW	UTH	FIM ,
م الم الم	1	Quell	-10			1917	-W, I	SABEL	A ST.	SAL	15BUR	4. MD.
cian and cian and cian and cian and cian-fransit	cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as Due to (or as	drat	nce of):						
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_D (U)	۵.	Part II. Other significant condition	ions contribi	uting to death b	ut not resultir	ng in the underl	ying cause giv	ven in Part I.	23e. Did to	bacco use	contribute to th	e cause of death
ned b e dela	>		Anto	en D	Seas	-			1 🗆 Y	es 2 🗆 N	lo Prob	ably 4 Unkr
n signed b	d by	Coronary									/	
been signed b should be deta	leted by	COPP							24a Mac	200		JSY IIIIUIII YS AVAI
has been sign je 2 should be	mpleted by	COPD							autop	sv	prior to cor	npletion of cause
ate has been sign page 2 should be	Completed by Physician/Med	COPD Metattati		cess in	volvine	Liver	p. 1988		autop perfor	med?	prior to cor death?	
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DHMH 17 Rev 1/2001

Hayes James 13816 3155

-	^		1 - For State Registrar	State of	Marylar	nd / Depa Cea	artmen	t of H	leaith a	and M	ental Hy	giene Rea. No	20	04	02	066
	_		Decedent's Name (First, Middle, La.	st)							2. Date of De		•		3. Time of	Death
•	Physici	an			- 1-						Month	Da		Year		P M
	/Media			n Lou Ha			4h Cihi	Town or	r Location o	4 Dooth	Januar	* 1	. County o	004	1912	P
100	Examir	ner	4e. Fecility Name (If not institution, giv	a str oe t and num	Der)				Location o	Death						
			Union Hospital		7 A = 2 // m + 1 m	land blokeland	If Under	cton	If Under 2	24 Hrs	Data of Dis		Ceci		(0)	
Ć2	Funeral		5, Social Security Number 6. S	ex □M 2⊠F	7. Age (In yrs.	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da				ece (State o	r Foreign
	Director		218-72-3137 Usuel Residence of Decedent		81	113.					AUG 12	, 19	22	Viro	inia	
	pue *		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	Od. Inside Ci	tv Limits
	anyla	7				•								"	1 ☑ Yes	
	8a-1	ctc	Maryland Cecil		E	lkton										
	ith th	Dire	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of Wi	hat Coun	try?	
	72 hours after death with the Maryland natural', or items 23a or 28a-f show dreal Examiner must be notified at	Funeral Director	619 East Pulask	i Highwa	ıy		2	21921				U	Inited	d Sta	ates	
	r deg	ne	11. Marital Status	12. Was Dece	dent Ever in U des?	l.S. 13.	Was Dece	dent of Hi	ispanic Orig	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race Black	- America , White, e		
9	afte or it	F.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes If Yes, Give	2 🔯 No				Specify:				Specify:			
8	ours	d by	3 X Widowed 4 ☐ Divorced	Year or Da	tes:			-11					Ороспу.	Whi	te	
21215-0036	72 h natu	ete	15. Decedent's Ed (Specify only highest gra			16a. Deced	dent's Usua kind of wo	al Occupa	ation du <i>n</i> ing most f)	of working	ng	16b. K	ind of Bus	iness/Ind	ustry	
2	within ene. than	ldu	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT u	se retired	1)							
	filed withi Hygiene. other than	Completed	1			Но	memak	cer					_Her		Home	
pu	d oth	Be	17. Father's Name (First, Middle, Last,						18. Mothe	r's Name	(First, Middle,	, Maiden	Sumame)		
<u>a</u>	should but and Ment	2	Luther S. Remin	es					Ida	a Mae	Atwel	1				
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Aura	Route Number	er, City o	or Town, S	itate, Zip	Code)	
	and 2 saith a n 27 is		Judy D. Asbury/	Daughter		407 N	C Hwy	7 32N	N, Sun	bury	, Nort	h Ca	roli	na 21	7979	
Baltimore,	- I 6 E	- 62	20a. Method of Disposition		20b. F	Place of Dispo	sition (Nar	me of	-	Ď	ate		ocation - C			
9	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif			Stelle Note					ry 21,	Col	ora,	Mara	bacts	
=	rtan rtan njur		21. Signa are of Funeral Service Licer		PE	esbyte	LIdII	Cellie ad Addres	s of Facility	, ZOC	/-1		OLa,	mar	Tanu	
Ba	Department of the concession o			N.	0	H	cks	Home	for I	Fune	cals, F	.A.				gegoren
	WILLIAM I		23a. Pert1. Enter the disease, or com	olications that ca	used the deal	th. Do not ent)3 W.	Sto	ckton	Stre	eet, El	ktor	ı, Ma			
			shock, or heart failure. List only	one cause on ea	line.	an. Do not ont	or the mod	a or ayıırı	g, such as t	cardiac o	i i ospii atory a	11031,			Approximate Interval Bet Onset and I	Jeath
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	neur	nonia	/							1	unkn	non
	/Medical Examiner		leading in death)	Due to (d	or as a consec	uence of):		1		2				1	inkn	C-14.
	LAGITITIO		Sequentially list conditions,	b. Chri	mic 0	bskucl	we!	um	onar	yu	isease				in	own
	D #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseq	(uence of):				1						
	and tran	E E	that initiated events resulting in death) Last	C												
760,	ie berexecuted vsician and e burial-transit	cal Examiner	Togething in doubly East	Due to (c	or as a conseq	(uence of):										
376		-		d						_						
89	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be delached for use as th	Completed by Physician/Med	IF FEMALE:										-			
Box	th ce rendi	an/I	23b. Was decedent pregnant	23c. If yes, outo	ome of pregnath 2 ☐ Feta		Ectopic p	regnancy					23d. Date			
	deal e ait	lcle	in the past 12 months?		int at time of c		Other (sp						Mont	ih l	Day ነ	'ear
P.O.	t the by th ache	hys	9 Unknown	9LJ UNKNO	wn						-,					
	res tha igned be de	y P	Part II. Other significant conditions of	-	ath but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco (use contrib	oute to the	e cause of d	eath?
Records,	quire on sig	pa	Altheroscler	10515							12	Yes 2	□No 3	Proba	ibly 4 🗆 L	Inknown
00	w requir been si should	let									24a. Was	an	24b. W	ere autop	sy findings a	available
Re	he la has ge 2	E									autor		pri de	or to com	pletion of ca	ause of
a											1 Yes		1 [☐ Yes :	2 No	
Vital	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	/			Othe	0.01		(Check only o		_			
ot .	> .9 ₽	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 210		ER/Outpatien 28b. Time of		28c. Injury	4 🗆 1401		ne 5 Resid)	
2	ding l	lo	1 ☑Natural 5 ☐ Pending	28 a. Date of (Month	, Day Yeer)	Injury		Work	</td <td></td> <td>8d. Describe t</td> <td>iow injui</td> <td>y occurred</td> <td>u</td> <td></td> <td></td>		8d. Describe t	iow injui	y occurred	u		
Sic	Attending r death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b				М		Yes 2□N							
Division of	or At ter d irect irect n by	Certification;	4 Homicide determined	286. Place	of Injury - At h g, etc. <i>(Specii</i>	ome, farm, str fy)	eet, factory	y, office		2	Bf. Location (S City or Tov	Street an vn, State	d Number)	or Rural	Route Num	ber,
	irs, al									1						
•	fosp t hou fune ely fil	cal	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medicel Exar	ysician: To the l	oest of my kno sis of examina	owledge, death	occurred vestigation	at the tim	ne, date and	d place, a	nd due to the	cause(s)	and man	ner as sta	ited. the cause(s	1
	To the Hospitel or Attending Phwithin 24 hours, after death To the Funerel Director: After the completely filled in by the funeral	Medical	one)	and mann	er stated.											
	To To	2	29b. Signature and title of certifier	_	4.8		290	c. License	o number			29d. Dai	te signed ((Month, E	ley, Year)	
			Jachde	13.	M		1	1)00	233				1.2	0.0	4	
			30. Name and address of person who	completed cause	of death (Iter	п 23а) (Туре,	Print)	-/-	2-	_	0/2	mi	2	1601	,	
			30. Name and address of person who S. S. Saddev	MD	118 No	eeth St	by	ule	23	E	Ryon		ox.	1/0/		
3	Sta Registi		31. Date filed JAN, 24,6°2004	2.32. Re	gistrar's Signa	ature	N. S.									

DHMH 17 Rev 1/2001

		1 _ State	aryland / Dep		lth and Mental Hy	giene	0206
Physici /Medio		Registrar 1. Decedent's Name (First, Middle, Last) MASON BYRD JONES			2. Date of Do Month JANUAG	Day Year	3. Time of Death 0256 M
Examir Funeral Director	ier	578-44-1803 ¹₹M 2□F					
Maryland a-f ahow	tor	Usual Residence of Decedent 10a. State 10b. County DELAWARE SUSSEX	10c. City, Town or Lo				10d. Inside City Limits
ath with the	Funeral Director	10e. Street and Number 17410 MEADOW DRIVE		10f. Zip Code 19933		10g. Citizen of What Co	
be filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene death with the Maryland of other than "natural", or items 23s or 28s-f show event. In Medical Exertit or med the inclined at		11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates:	No		nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)		
C	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupetion kind of work done durin DO NOT use retired) ISTANT MANA	g most of working	16b. Kind of Business. A.&.P. TE	•
inial y latification 2.1.6. d 2 should be filed within the and Mental Hygiene. 17 ts merked other than traumatic event. It a Mental traumatic event.	To Be Co	17. Father's Name (First, Middle, Last) NEUTON WILTON JONES			Mother's Name (First, Middle LORENA FENTON	•	
nd 2 alith a 27 ts	0	19a. Informant's Name/Relationship (Type, Print) DONNA H. JONES/ WIFE 20a. Method of Disposition		10 MEADOW I	Number or Rural Route Numb RIVE, BRIDGEV Date		933
Page nn: if		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fureral Service Lipensee M0086	WASHINGTO CEMET	matory or other place) ON NATIONAL	01/13/2004	WASHINGTON	, D.C.
permit. Departm Importa any inju	L M	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	the death. Do not en	2 LAWS STRE	ET, BRIDGEVIL		
Physician /Medical pe executed be executed Examiner and street private fransit as the private fransit	edical Examiner	Sequentially list conditions, if any, leading to initiation cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of): a consequence of):	farction			Onset and Death
the death certify the attending ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death to	out not resulting in the u			tobacco use contribute to Yes 2 No 3 Pr	the cause of death?
	e Completed	COPD			1 ☐ Yes	psy prior to death? 2 No 1 ☐ Yes	topsy findings available completion of cause of 2 \square No
tending Physeath.	Certification: To Be	27. Manner of Death Natural 5 Pending 28a. Date of Inju (Month, Da investigation 1 1 1 1 1 1 1 1 1	y Year) Injury ury - At home, farm, str	nt 3 DOA Other: 4 f 28c. Injury at Work? M 1 Yes	2 No	dence 6 Other (Spechow injury occurred	
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (check only one) Certifying Physicien: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in	n occurred at the time, do	ate and place, and due to the n, death occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
within To H	M	29b. Signature and title of certified 30. Name a d address of person who com, teled cause of c	leath (Item 23a) (Tyne	29c. License nur 1533		29d. Date signed (Month	n, Day, Year)
Sta Registr		31 Date filed (Morth Day Year) 32 Begistr	ar's Signature	Sporks	8.94 T. SALISA	ref mo	

			rieas			d / Departme				raiene	,	
		•	For State Registrar	State of Ma	iryiair	Certifica			vientarriy	Reg. No. 2	004	02068
			Decedent's Name (First, Middle,	Last)					2. Date of De		Yeer	3. Time of Death
	Physicia /Medic		Lena Jen	KINS					Oi	05	2004	1920 "
	Examin		4a. Fecility Name (If not institution,	1		4b. City	, Town, or	Location of Death	1	1 1/	ity of Death	~ .
3.			5. Social Security Number		(In vrs	last birthday) If Und	er 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birtho	lace (State or Foreign
- 1	Funeral Director		213-22-7483		37	Yrs. Months	Days	Hours Min.	(Month, Di	ay, Year) 24,1916		yland
	D .		Usuel Residence of Decedent 10a. State 10b. County		10c Cib	, Town or Location					1	Od. Inside City Limits
	shov	5			TOC. Oil							1 X Yes 2 □ No
	28a-f	Director	Maryland Wicom	100		Salisbury 10f. z	ip Code			10g. Cilizen o	What Cour	ntry?
	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Exerting must be notified at	0	1014 Limestone	Court			2180	4		US	A	
	ems 2	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13. Was Dec	edent of H	spanic Origin? (Si n, Mexican, Puert	pecify Yes or No Rican, etc.)	o- 14. R	ace - Americ lack, White,	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	0	1 ☐ Yes	2 X No	Specify:		Spec	iiy: wh	ite
8	tural sed Ex		15. Decedent	s Education		16a. Decedent's Us	ual Occup	ation		16b. Kind of	Business/In	dustry
215	hin 72	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5-	+)	(Give kind of w life. DO NOT	rork done d use retired	turing most of wor.)	king			
7	filed with Hygiene. Ather ther	Completed	9	_		Homemaker	:	40 Markada Na	(Fire & Sindella	Domes		
pue	2 should be filed within 72 hours after death with the Marylar and Mantal Hyglene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", and it is marked other than "natural is inclified at raumatic event, the Medical Exemptral manual is inclified at	Be	 Father's Name (First, Middle, L George W. Smul 					18. Mother's Nam	Phippir		arrie)	
<u> </u>	should and Men is marke sumatic	၉	19a. Informant's Name/Relationsh			19b. Mailing Addre	ss (Street				m, State, Zip	Code)
S	ges 1 and 2 should it of Heetth and Mer if item 27 is marks or other traumatic		Sylvia Poole/da	ughter		1014 Lin	nesto	ne Court,	Salish	oury, MI	2180	4
Je,	of Hee		20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation	2 Demoved from State	20b. P	lace of Disposition (Nemetery, crematory or	ame of other plac	θ)	Date	20c. Location	n - City or To	own, State
Ĕ	Pege ment ant: li		*4 □Donation 5 □Other (Sp		Wio	omico Memori		1			bury,	
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2: Department of Heelth ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service L	toure (PSO-	Hollo 501 S	and Addresoway I Snow I	Suneral H Hill Rd.,	Home Pro	ofession oury, MI	nal As 0 2180	sociation 4
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Dec.									
	Physician		Immediate Cause (Final disease or condition	ASC	VD							Oliser and Death
	/Medical Examiner		resulling in death)	Due to (or as a	Α.	uence of): Fai	144	Q				
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	_		10(1					
	ite be executed sysician and ne burial-transit	Examiner	that initiated events	С								
760,	e be executed /skcian and e burial-transit		resulting in death) Last	Due to (or as a	conseq	uence of):						
876	cate b	dical		d								
9 X	certifi ding I Ise as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. I	Date of delive	эгу
B	death e atter	iclar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown							Month	Day Year
P.O	at the by th	hys	9 Unknown	1					on Did			and a death?
Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certificat r this certificate has been signed by the attending phy ral director, page 2 should be detached for use as th	d by	Part II. Other significant conditio	ns contributing to death bu	it not res	ulting in the underlying	cause giv	en in Part I.		Yes 2 □ No		ne cause of death?
00	s beer s shou	Completed							24a. Was		. Were auto	psy findings available
Re	sicien: The law certificate has E irector, page 2 s	шо							auto perf 1 ☐ Yes	ormed7 2 2 No	death?	mptetion of cause of 2□ No
<u>ita</u>	sien: artifica ctor. p	Bec	25. Was case referred to medical examiner?	Hospital:				26. Place of Dea	ith (Check only	one)		
of <	Physic this co	၉	1 ☐ Yes 2 No		ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
G	ding I h. After funer	tlon	27. Manner of Death 1 Natural 5 Pending investig		Year)	28b. Time of Injury M	28c. Injur Wor	k? Yes 2⊡No	200. Describe	now injury occ	anea	
Visi	Atten r deat ector: by the	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of Inju	ry - At h	ome, farm, street, facto				(Street and Nui	mber or Rura	al Route Number.
Ö	rs afters all Dir	Cert	4 - Houncide	building, etc	(Opecin	, , , , , , , , , , , , , , , , , , ,			Only dr. 70	, otato)		
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyin (Check only 2 Madical I	g Physician: To the best of Examiner: On the basis of and manner sta	examina	wledge, death occurre tion and/or investigation	ed at the tir on, in my o	ne, date and place pinion, death occu	, and due to the irred at the time	cause(s) and date and plac	manner as si e, and due to	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				9c. Licens			29d. Date sig		
			> Dan	M.D				7952		1/7/	206.	4
NDQ			30. Name and address of person Babulal Dan		eath (Iter	n 23a) (Type, Print)	<i>B</i> 4	B. S.	lisbur	19, M	021	804
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 08	2004 32. Registra	ar's Signa	ture & A	ouk.					

		For State Registrar		of Marylan		artment of H tificate of L			Reg. No. 2	004	02069				
Physici	an	1. Decedent's Name (First, Middl	e, Last)			2. Date of De.	nth Day Year								
/Media		CARL	В.	KENNA	RD	4b. City, Town, or	Location of D	Januar	11	2004 ty of Death	0933 4				
Examir	er	4a. Facility Name (If not institution PENINSUUR NEG	-		SNIFK		11360		-	(CAMIC	0				
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24	HIS. 8 Date of Bird	h	9. Birtholad	ce (State or Foreign				
Director		154-09-8834	1 ≛ M 2□F	81	Yrs.	Months Days	Hours N	Min. (Month, Da 6/22/1	L 922	Md Country	<i>'</i>)				
pu ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation				104	I. Inside City Limits				
anyla shov	<u>_</u>									100	1 Yes 2 No				
Z8a-f	Director	Md Wicom 10e. Street and Number	N	antico	10f. Zip Code			10a. Citizen o	What Country	17					
with		2805 Hickm	21840	•		U.S.A									
be filed within 72 hours after death with the Maryland ial Hygiene. d other than *natural*, or items 23e or 28e-f show event, tra Medical Exactinar must be redified at	Funeral	11. Marital Status	12. Was De	ecedent Ever in U	.S. 13. V	Vas Decedent of Hi	ispanic Origin'	? (Specify Yes or No	- 14. Ra	ace - American					
or Iter	Ē	1 Never Married 2 Mar	ried X Ye	Forces? s 2 No Give 194:		Yes, specify Cuba	n, Mexican, Pi Specify:	uerto Hican, etc.)		ack, White, etc					
hours after tural', or ite	l by	3 Widowed Divorced	If Yes, Year or	Dates: 194	4	Yes 2 No	<i>Зрвспу</i> :		Spec	ity: Blac	X.				
72 h	etec	15. Deceder (Specify only highe	nt's Education st grade complete	ed)	16a. Deced (Give	tent's Usual Occupa kind of work done of DO NOT use retired	ation during most of	working	16b, Kind of	Business/Indus	stry				
hen.	Completed	Elementary/Secondary (0-12)	_	e (1-4or 5+)			,		771.4		_ =				
filed within 72 Hygiene. Ither then *nal		17. Father's Name (First, Middle,	Last)		Elec	ctrican	18. Mother's	Name (First, Middle,		ectri	al				
d be i	b Be	Unknown					IInk	novn		,					
2 should and Men is marke aumatic	ဥ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street a		r Rural Route Numbe	er, City or Town	n, State, Zip Co	ode)				
Ting I		Eleanor- Fr	iend		2805	5 Hickma	n Lan	e, Nanti	coke.	Md 2	1840				
~ 포 등 등		20a. Method of Disposition		'	Place of Dispo	sition (Name of natory or other plac		Date		- City or Town					
Peges nent of int: If it		1 © Burial 2 □ Cremation `4 □ Donation 5 □ Other (S		m State		Cemeter		16/04	Hur1o	ck.Md	21643				
permit. Pege Department of Important: If sny injury or once.		21. Signature of Functor Service	Licensee	0-417	22	. Name and Addres		ral Home							
80E 5 8		1 oneling W	Besiel					yland 2		· Bon					
		21a. Part1. Enter the disease, shock, or heart failure.	complications that only one cause o	at caused the deat n each line.	h. Do not ente	er the mode of dying	g, such as car	diac or respiratory as	rest,	In	pproximate iterval Between Inset and Death				
Physician		Immediate Cause (Final disease or condition	a Ċ	INGEST	TIVE	HEA	37	FAILUR	NE.		riset and Death				
/Medical Examiner		disease or condition resulting in death) a. UNCESTIVE HEART FAILURE Due to (or as a consequence of):													
LXdiffiller	<u> </u>	Sequentially list conditions,	b	to (or as a conseq	TI V	EL	OMYU PAT	NYU PATHY							
ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
death certificate be executed e attending physicien and ad for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	to (or as a conseq	uence of):										
sate be executed hysicien and the burial-transit	dlcal E														
g phy as the	edlo		0.												
attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pregnancy				ate of delivery					
dean ne atte	Sicla	in the past 12 months? 1 □ Yes 2 □ No		egnant at time of d		Other (specify)			N	Ionth Da	ay Year				
res inei me de signed by the a be detached f	hy		9 ☐ Unknown												
requires that the leen signed by th hould be detache	by	Tall II. Other significant continuous contin								3 Probab	Σ				
been si should t	Completed							_	es 2 10	3 Flobab	iy 4 Daprikilowii				
1st 2s	nple							24a. Was autop	isv	. Were autopsy prior to comp death?	y findings available letion of cause of				
ate	Co							1 Yes	rmed2 2 No	1 Yes 2	□ No				
ysician: in is certificate director, pag	Be	25. Was case referred to medica examiner?	Hospital	☑Inpatient 2 □	ER/Outpatien	t 3 DOA Othe	ar	Death (Check only o			-				
this aldii	P.	1 Yes 2 No 27. Manner of Death	ng Home 5 Resident												
ding h. After tune	tlon	1 Natural 5 Pending (Month, Day Year) Injury Work?							28d. Describe how injury occurred						
or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could	not be 28e. Pla	ace of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (S	Street and Nun	ber or Rural A	loute Number,				
7 9 5	erti	4 Homicide determ	bu bu	ilding, etc. (Specif	(y)			City or Tox	vn, State)						
To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical C	(Check only 2 Medical	Examiner: On the	e basis of examina				lace, and due to the							
the I	Medi	one) 29b. Signature and title of certifie	and m	anner stated.		20c License	number		20d Date sign	ed (Month Da	v Vear)				
7 × 0 0		Signature and the or certific	ad.	h		nna	a 10		1 - 1	- // //	,/				
LIVA		my M	rinn	ause of door fire	n 23a) /T	Print)	117		1-6	-09					
		30. Name and address of person	hod NIC	ause of death (Iter	п 23a) (туре, 4	100 E. 3	hore	Dr. s	1215	bUM	NO				
Sta	ite	31. Date filed (Month, Day, Year) 32	. Registrar's Signa	ature 4	Anna Va	/								
Regist		JAN 0 9	2004	French	~	17000									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Ma	aryland / Depa <i>Cei</i>	rtificate of			ene g. No. 20 (0 4 0	2070			
Dhamisis	1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month		3. Tir	ne of Death			
Physician /Medical	HARRIS V. LEWIS					Jan.	6, 2004 5:4		45 PM			
Examiner	4a Facility Name (If not institution,	give street and number)			4b. City, Town, or Lo		4c. County of (
, and the second	Salisbury Rehab	and Nursing	Center	If Under 1 Year	Salisbur If Under 24 Hrs.	y, Md.	Wicor					
Funeral Director	222-10-7879	6. Sex 7. Ag 1 M 2 □ F	e (In yrs. last birthday) 81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 07-21-1	9. Birthplace (S Country) MARYLAN		D Poreign			
ž	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Insi	de City Limits			
f show	MD WICOMICO WILLARDS											
or 28e-f s northe	10e. Street and Number			10	g. Citizen of Wha	it Country?						
1 0	6378 POWELLVILL	E ROAD		21874			US	USA				
Examiner must be notified by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married Z∑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, specify Cuban, Mexican, Pue If Yes, Give Year or Dates:						Black, V	American India White, etc. WHITE	ın,			
event, the Medical B Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	(Give		pation during most of working d)	ng 1	6b. Kind of Busin					
T LO	7			FARMER				LNG				
atic event, To Be C	17. Father's Name (First, Middle, L	ast)				(First, Middle, M	aiden Surname)					
2	ROLAND C. LEWIS		201 14 70		ADA TAAR	(Davida Musebas	FARMING fumber, City or Town, State, Zip Code) LARDS, MARYLAND 21874 20c. Location - City or Town, State -04 WILLARDS, MARYLAND FUNERAL HOME, INC. ALISBURY, MARYLAND 21804 Dry arrest, Approximate Interval Between Onset and Death					
	19a. Informant's Name/Relationsh BETTY LEWIS - S								874			
other		FUUSE	20b. Place of Dispo	sition (Name of								
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any in	27. Signature of Fin eral Service L	N - Z							21804			
etending prysician and Signature of Signatur	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. forther	Due to (or as a consecutive to (or a consecutive	quence of):				7-1				
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actor, page 2 should be usuationed for use Be Completed by Physician/M				24a. Was an perform		24b. Were auto available p completion of death?						
I director, paga 2						1 T Yes	3 2 KHO	1 ☐ Yes	2 No			
S S	25. Was case referred to medical	3-0-5			26. Place of Death	(Check only one	»)					
	examiner?	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3LL DOA		me 5 Resider	nce 6 Other ((Specify)				
funera tion:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation	ryat rk?]Yes 2 □ No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,								
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completely filled in by the Medical Certifical	29a. Certifier 1 CertifyIng (Check only one) 1 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination and/or in	h occurred at the ti vestigation, in my o	me, date and place, a opinion, death occurr	ed at the time, da	te and place, and	due to the ca				
W	29b. Signature and title of certifier	DA		29c. Licens	se number	29	d. Date signed (M	Month, Day, Ye	ear)			
M	30. Name and address of person v William H. Ro 31. Date filed (Month, Day, Year)	I. W. 2 mide	death (Item 23a) (Type	1346 s.	Division	St.Suite	,Salisbu	ıry, Md	.21804			
State Registrar			eners /	g space	Ks .							

DHMH 16 Rev 6/95

To the Hospital or Attending Physician:

15%

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** Donald P. Mosier /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 8-8-1934 69 Ń.J. Director 158-24-4845 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Delmar Director Wicomico Md. 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 21875 9485 Melson Church Road Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic exercise." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Building Contractor Carpenter 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irma Pellington Mosier Peter I. Mosier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delmar, Md. 21875 Gayle M. Mosier, Wife 9485 Melson Church Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 1-9-04 Delmar, De. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home, Inc. 21. Signature of Funeral Service Licensee CLUL 13 E. Grove St. Delmar, De. 19940 23a. Part 1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Idio pathic ULMonary Pnysician /Medical Due to (or as consequence of): Examiner Sequentially list conditions, Sequentially list condition to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by filled in by the funeral director, page 2 should be 4 Dunknown 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 TYes 2 19 No Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 2 1 ☐ Yes 2 ☑ No 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Prineral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sulisbury MD. 21804 KURT Webberg 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici /Medio		John	Mark		Mck	Kenzie	. S:	r.		Januar	y 16,	2004	1055 A.M		
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an	d be ental	To Be	James	Kenn	eth	McKer	nzie		Mar	ilyn	Ma	rior	ie	Evans		
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ore,	of He of He f Item r oth		20a. Method of Disposition 1 Burial 2 XX remation 3		20b. PI	ace of Dispo	osition (Nam matory or of	ne of ther plac	e)	Di	ate	20c. Locat	tion - City or T	own, State		
Ĕ	Peg ment ent: i		'4 □Donation 5 □Other (Special		Cum						3/2004					
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23e or 28e-f ehow any injury or other treumatic event, Ite Wedical Examiner must be notified at ODGs.		21. Signature of Funeral Service Lice	1SEE		22										
	20 = e 0		1 Tarilou_	111.00	wew	Do not on							urg, m			
			shock, or heart failure. List only	one cause on each	tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Contact gunshot would be held.									Interval Between Onset and Death		
7	Physician /Medical		disease or condition resulting in death)	a. Due to (or a:			let L	VU-	-01	70	40					
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×ε	eath certificate be executed attending physician and for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								230	3. Time of Death 1055 A.M 1055			
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical Certification:	(Check only 2 Medical Exa	miner: On the basis	of examinat	wledge, deat ion and/or in	th occurred ivestigation.	at the tim	ne, date an pinion, dea	d place, a	and due to the co	ause(s) an ate and pla	d manner as :	stated. o the cause(s)		
	the Phin 24 the F	Medi	one)	and manner s	tated.				e number							
	With To Com	-	29b. Signature and title of certifier	e,-		290		C.M.E	,							
			30. Name and address of person who	completed cause of	death (Ita-	23a) /Tuna	Print)		C.PI.E	•			-1 201			
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		1 _ State		tment of Health and ificate of Death		ene 1.No.2004 02073
		Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physi		William D. O'Oui	n Jr.		January	Day 2004 /230 M
/Med Exam		4a. Fecility Name (If not institution, give street and number		4b. City, Town, or Location of Dear		4c. County of Death
		PENINSULA REGIONAL MEDIL	m/ CONTU	SALISBUM		HICOMICO
Funera		1XIM 2□F	Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Y	9. Birthplece (State or Foreign Country)
Directo	r	266-20-3045 Usuel Residence of Decedent	77 Yrs.		May 2, 1	1926 Florida
land		10a. State 10b. County	10c. City, Town or Loca	ation		10d. Inside City Limits
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in with the Maryla 23s or 28s-f shov	Director	10a. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
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ter deal	Funeral	11. Marital Status 12. Was Decede Armed Force	s? If '	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36 safte	by Fi	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 If Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	□No Navy	☐ Yes 21 No Specify:		Specify: White
d 21215-0036 filed within 72 hours atter death with the Maryland Hygiene. thar than "natural", or teems 23a or 28a-1 show ont, the Mydical Examinat the profilied at	ed t	15. Decedent's Education	16a. Decede	nt's Usual Occupation	16	5b. Kind of Business/Industry
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aryland should be nd Mental i marked o	2	William D.	O'Quin S			- Tillman
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C - 14 F		William O'Quin, III - Son 20a, Method of Disposition	20b. Place of Disposi	tion (Name of		Court House, NJ 08210 Oc. Location City or Town, State
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		23a. Pañ1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not enter	the mode of dying, such as cardia	c or respiratory arres	t, Approximate Interval Between
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/Medica	al"	resulting in death)	as a consequence of):	1 -		211
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-30 4. 760, be exacuted sician and burial-transit	хап	that initiated events c	as a consequence of):			
GUIN 266-20-304 Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicalE					
687 ificate g physias the	edic	U				
Box 6i eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco		Ectopic pregnancy		23d. Date of delivery
B. B death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nt at time of death 5 🗆	Other (specify)		Month Day Year
P.O. that the did by the detached	Phy	9 Unknown		deskilan anuan swan in Dard I	23a Did toba	acco use contribute to the cause of death?
IS, FISTER SIGNED	þ	Part II. Other significant conditions contributing to deal	/	Jenying Cause given in Parti.	1 ☐ Yes	.
ecords, law requires that as been signed in the contract of th	eted		. 1	1 - 1 - 1		
Recorded the state of the state	ompleted	Beabound and 10 cm	vonic right	up distocati	24a. Was an autopsy performe	prior to completion of cause of death?
Vital Redicion: The Centificate historic, page	e Co	25. Was case referred to medical		26 Place of Do	1 ☐ Yes 2)	No 1 Yes 2 No
9 10	To Be	examiner? 1 Yes 2 No Hospital: 1 X Inp	patient 2 ER/Outpatient	Other		ce 6 ☐Other (Specify)
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To the Hospital within 24 hours a To the Funeral completely filled	ica		is of examination and/or inve	occurred at the time, date and place estigation, in my opinion, death occ		use(s) and manner as stated. te and place, and due to the cause(s)
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	Examir Funeral	ner	26036 Porter M	ill Rd		. last birthday)	He If Under	ebroi	1 If Under 2		8. Date of Birth (Month, Day	W	icomico	
	Director		218-30-0936 Usual Residence of Decedent 10a. State 10b. County	1 □ M 2 □ ¥F	80	Yrs.	Months	Days	Hours	Min.	August 5	, 1923	Mary	place (State or Foreign ntry) rland
	th the Maryla or 28a-f ehor o notified at	Director		mico		Hebron	10f. Zip	Code			1	0g. Citizer	of What Cour	1 ☐ Yes 2 🛂No
9	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or itams 23e or 28e-f ehow event, the Mcciral Exeminar must be mailted at	Funeral	25997 Porter 11. Marital Status 1 Never Married 2 Marrie	12. Was Decede Armed Force	s?	,	Was Decedifyes, spec		spanic Orig n, Mexican,	gin? (Spec , Puerto F	crfy Yes or No- Rican, etc.)		Race - Americ Black, White,	etc.
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	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ex	To	19a. Informant's Name/Relationshi Diane P. Drisco		r				nd Number	r or Rural	Route Number Hebror	City or To		Code)
altimore,	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	ecity)		Place of Dispo- cemetery, crem ringhill	Memory Memory	Garc	ens	1/8/	′04	Hebi	ion - City or To	
Ba	Dermi Depa Impo any ir once		21. Signature of Funeral Service L	rucy (f	SP sed the deal		DOT 2	now	нттт	Ra.,	Salisk	bury,	ional A MD 218	
2	Pnysician /Medical Examiner		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a	as a cons	lac.	_6	1	- 12 - 12	mia)	351,	-	Approximate Interval Between Onset and Death
,00	icate be executed physician and sthe burial-transit	i Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last	с.	as a conseq	V	4 (NVO	ey 8	<i>U)3</i>	ease_			10yrs
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on or vital	Phys this al di	ion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpa		ER/Outpatient 28b. Time of Injury	28	c. Injury Work	4 Nurs	sing Hom-	Check only one 5 Reside 8d. Describe ho	nce 6 🗹		Home.
DIVISION	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	njury - At ho etc. <i>(Specif</i>	ome, larm, stre y)	et, lactory,		es 2 No		Bf. Location (Str City or Town	eet and Nu State)	umber or Rural	Route Number,
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_	- 3 F 8		Be use 30. Name and address of person with	So completed cause of	death (Item	23a) (Type. F				050				
D	Stat Registra	te	BENITO 31. Date filed (Month, Day, Year)	8. C	HA M	0 13	100	Soup	<u>K</u> D) iV/3i	~ C/. S	22 3	01 Sat	64 My, 40 1804

			1 - For State Ragistrar	State of Marylan		artment of rtificate of		Re	g. No. 2004	02075
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Catherine Ma Aa. Facility Name (If not institution, give in the content of	e Randall			or Location of Dea	2. Date of Death Month Januar	Day Year y 13, 2004 4c. County of Death	
7	Funeral Director		10816 Pam Driv 5. Social Security Number 214-32-8568 Usuel Residence of Decedent		last birthday) Yrs.	Wa. If Under 1 Yea Months Days				cles place (State or Foreign placy) aryland
	se Maryland 8a-f ehow zilfied at	ector	MD 10b. County Charle		y, Town or Lo Valdor					10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ehow important: If item 27 is marked other than "natural", or items 23e or 28e-f ehow apply injury or other traumatic event, Ite Modical Expinitive runal by nullified at ance.	Funeral Director		E 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 X No	S. 13. \		603 Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	g. Citizen of What Cou USA 14. Race - Ameri Black, White,	can Indian,
15-0036	in 72 hours af	Completed by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Edu (Specify only highest grade	ff Yes, Give Year or Dates: cation e completed)	16a. Deced	1 ☐ Yes 2 X No dent's Usual Occu kind of work done DO NOT use retin	upation	orking 1	Specify: W	White Industry
Maryland 21215-0036	ould be filed within. Mental Hygiene. arked other than ". atic event, Ite M.	Be	Elementary/Secondary (0·12) 12 17. Father's Name (First, Middle, Last) Benjamin Barth	Coflege (1-4or 5+)		nager	18. Mother's Na	me (First, Middle, M		<u>.</u>
e, Maryl	1 and 2 should be Health and Mental em 27 is marked thar traumatic ev	To	19a. Informant's Name/Relationship (Ty, Randy Randall/S	pe, Print) ON	1081	6 Pam I	ot and Number or A Drive, Wa	ural Route Number, aldorf,M	City or Town, State, Zip.	
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or oths once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Br	insfi	sition (Name of natory or other place) e1d-Ec1 Name and Addin	nols 1/1	L5/04 C1	harlotte L HOME, P.	Hall,MD
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o	nding Physicii ath. r: Alter this cer e funeral direct	ation: To Be	evaminer?	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 - Nursing I		ce 6 □Other (Specif	n
Division	Hospital or Atta 44 hours after de Funeral Directo tely filled in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	/)			City or Town,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	estigation, in my	ime, date and place opinion, death occi	urred at the time, date	e and place, and due to d. Date signed (Month,	Day, Year)
P	Pas		30. Name and address of person who co	impleted cause of death (Item	23a) (Type, I	Print) L	1535 Na	Krish)-)4-0 an Mathur	1
È	Sta Registr		31. Date filed (Month, Gax, Year) 6	32. Registrar's Signar	ture	your		50		

		1 - For State Registrar	State of Maryland	/ Depa		lealth and		giene		L ₃	02076
Physici /Medi	cal	Decedent's Name (First, Middle, Last) David Le	ee Schirling, S	Sr.	4b. City, Town, o	Language of De	2. Date of D Month	18	y Yes	ır	Time of Death
Examir Funeral Director	ier	4a. Fecility Name (If not institution, give s Union Hospital 5. Social Security Number 218-40-6884 6. Sex		t birthday) Yrs.	Elkton If Under 1 Year Months Days	If Under 24 H		rth ay, Year	Cecil 9.1		(State or Foreign
be filed within 72 hours after death with the Maryland tall Hyglene. do other than "natural", or flems 23a or 28a-f show event, the Medical Enantmer must be notified at	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Cecil 10e. Street and Number 262 Hollingsworth	Manor 2. Was Decedent Ever in U.S. Armed Forces? Vietn 1 XYes 2 No 1 f Yes, Give Year or Dates: (ation completed	ton 13. 16a. Dece (Give life.	cation 10f. Zip Code 21921 Was Decedent of H f Yes, specify Cuba 1 Yes 2 No Jent's Usual Occup kind of work done DO NOT use retired Litary Po	specify: ation during most of the state of t	(Specify Yes or N erto Rican, etc.)	10g. Ci	Inited 14. Race - A Black, W Specify: Cind of Busine partme fense	10d. II 1 Country? State merican Inhite, etc. White	nside City Limits
permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic eve once.	То	19a. Informant's Name/Relationship (Typ. Vicky L. Frazier) 20a. Method of Disposition 1 [X]Burial 2 [Cremation 3] Rev. 4 [Donation 5] Other (Specify) 21. Signature of Puneral Service Courts)	Daughter 20b. Plac Safe Chur	4 Wal	ag Address (Street ding Coun sition (Name of patery ar other plan the defectory Name and Addre icks Home 03 W. Sto	odist 22	Rural Route Number Last, Date January , 2004	Mary 20c. L New	or Town, State land 2 ocation - City vark / D	1901 or Town, s	State
A project of the project of the project of the private franching the project of the private franching the priv	Ical Examiner	23a. Pert1. Exter the disease, or complished for heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leculing to animediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	Fance of): Why hee of):	UNE		liac or respiratory	arrest,		Inte	oroximate rval Between et and Death
nat the death certificate I d by the attending physi letached for use as the b	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3	Ectopic pregnancy				23d. Date of Month	delivery Day	Year
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tending Physicien: The Beath. Ior: After this certificate the funeral director, pag	Certification: To Be Co.	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		VOutpatier Bb. Time o Injury e, farm, str	28c. Injur Wor M 1	er: 4 🗆 Nursin	1 Yes Death (Check only g Home 5 Res 28d. Describe	one) idence how inju	6 Other (S	pecify)	
To the Hospital of At within 24 hours after of To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier (Check only one) 29b. Signature and title of certifier	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, deat n and/or in	vestigation, in my o	pinion, death o	ace, and due to the ecurred at the time	, date an) and manner of place, and country in the signed (Mo	onth, Day,	Year)
Sta Regist	ate rar	30. Name and address of person who co RODINEY DON'HAM, D.O. 31. Date filed (Month, Day, Year)	30 Joseph Struct	FT . 6	IM GODIS)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 РМ 9:47 January Silver, 5th Francis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Vest Virginia 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year 5. Social Security Number **Funeral** Jan 4, Yrs West 88 236-14-6488 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28e-f show traumatic event, the Medical Exemities must be multiled at MD 1X Yes 2 □ No Chesapeake Beach Calvert Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20732 U.S.A. 3813 Harbor Road Completed by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give 1944 Year or Dates: 1 ☐ Never Married 25 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Scientific Engineer i. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kate Bishop Gray Silver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3813 Harbor Road, Chesapeake Beach, MD 20732 Janice G. Silver, Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 1/22/04 Leesburg, VA 4 □ Donation 5 □ Other (Specify) Union Cemetery 2) Signature of Funeral Service Licensee 22. Name and Address of Facility
Colonial Funeral Home
201 Edwards Ferry Rd NE, Leesburg, VA 20176 23a. Part1. Enter the rise se shock, or heart filure e complications that caused the deal only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner arkinson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in july) that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and is the burial-transit law requires that the death certificate be executed Carebio Due to (or as a consequence of) Box 68760, Physician/Medical use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten e detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown this certificate has been signed la director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 PNo 24a. Was an 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗷 No 1 Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 060390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Hospital 1 aber hosels 2004 31. Date filed (Month Ry, 2026 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Glenmore Townsend 2004 Tenuany /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HI COMICE ecoloNA MediCM CONTOR PENINSULA SAL136U14 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 1y 15 Birthplace (Stete or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Hours Min 10XM 2□ F Yrs. Maryland May 1930 Director 214-28-7865 73 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow emp injury or other traumatic event, Ita Medical Examination at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Wicomico Delmar 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 29191 Waller Road 21875 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 Coltege (1-4or 5+) Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ollie Townsend Ida Mae Gale 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Waller Rd.Delmar, Md. 21875 Ina Townsend_(Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 10/04 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Mem.Garden 4 Donation 5 Other (Specify) Hebron, Md. 22 Name and Address of Facility Stewart Fune: 821 West Rd. S 21. Signature of Funeral Service Licenses Funeral Home Rd.Salisbury,Md.21801 Gladys B. Stewar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner iii The law requires that the death certificate be executed sicien and burial-tran Due to (or as a consequence of): attending physicien I for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 2 No 1 Yes Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ŧ ٩ 2 ER/Outpatient 3 DOA this o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funerel Direct completely filled in by 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2115 MIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 08

US

32. Registrar's Signature

JA LICKHAY

	an	1. Decedent's Name (First, Middle, La								2. Date of I Month	Day		Year	3. Time of	
Medic		Ellis Warren Tay								Jan	07		004	1:33	P^
camir	ner	4a. Facility Name (If not institution, give 626 Senior Way	ve street and number)				Town, or t alisbu		of Death		4c.		of Death	~~	
			Sex 7. Age	(In yrs. las	st birthday)			If Under:	24 Hrs.	8. Date of E	Birth	MT	COMIC		r Foreio
eral				73	Yrs.	Months	Days	Hours	Min.	March March	Day, Year)	30		lace (State or try)	
3		10a. State 10b. County			Town or Loc								11	0d. Inside Cit	y Limit
Illian	Director	MD Wicomi	.co	Sa.	lisbur	СĀ					,			1 🙀 Yes	2 🗆 N
event, the Medical Examiner must be notified at	Dire	10e. Street and Number 626 Senior Way				10f. Zip	Code 21801				10g. Citiz		/hat Coun		
Tenas	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V			spanic Orie	nin? (Sp	ecify Yes or I	NO- 1		S.A.		_
iner	F	12 Never Married 22 Married	Armed Forces? 1 ∑Yes 2 ☐ N	_	If	Yes, spec	cify Cuban	ı, Mexican	, Puerto	Rican, etc.)		Black	k, White, e	etc.	
Eva	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		. 1	□Yes	2LXNo	Specify:				Specify:	Blac	ck	
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matic ev	To B	Lloyd Taylor						Dais	ev N	lutter					
other traumatic		19a. Informant's Name/Relationship			19b. Mailing	g Address				al Route Num	ber, City or	Town, S	State, Zip	Code)	
er tra		Warren Taylor/son						ne, S	alis	bury,	MD 21	801			
or othe	11	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	☐Removal from State	20b. Plac	e of Dispos netery, crem	sition (Nan natory or o	me of other place)	,	ı	Date	20c. Loc	ation - (City or To	wn, State	
lury		* 4 □ Donation 5 □ Other (Speci	(y)	Green	n Acre					2004	Sal	isbu	iry,	MD	
any injury or of once.		21. Slocalism of Fundral Service (Service)	Tsee		Le	wis l	nd Address N. Wa	ıtson	Fun	eral H	ome				
- (23a. Part1. Enter the disease, or com	splications that caused	the death	16	18 W	est R	d.,	Sali	sbury,	MD 2	1801		Approximate	
		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	and dodin.						or recoiretone					
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State Registrar 31. Date filed (Month, Day, Year) JAN 0 7 2004

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

			1 – For State Registrar	State of Man		artment of H tificate of I			ene g. No. 2004	02081
	Physici	an	Decedent's Name (First, Middle, Lateral Alice Olivia Este					2. Oate of Death Month	Day Year 3 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, given PENINSULA RUSSIA)	e street and number)	CENTER		Location of Death		4c. County of Death	
e j	Funeral Director		5. Social Security Number 6. S		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	Year) 9. Birth	place (State or Foreign intry)
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo					10d. Inside City Limits 1127 Yes 2 ☐ No
	or 28a-f	Directo	MD Worceste	er	Snow Hi	10f. Zip Code		10	g. Citizen of What Cou	
036	be filed within 72 hours after death with the Maryland tal Hygiene. Idea dyler than "naturel", or Items 23a or 28a-f show event, I'm Medical Exacting rough be notified at	by Funeral Director	105 Gunby St. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		21863 Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 ▼ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	U.S. 14. Race - Ameri Black, White Specify: Black	, etc.
21215-0036	ed within 72 ho giene. er than "natur er than "natur er the Medical."	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired Head Star	during most of wor t Teache	r	6b. Kind of Business/Ir	•
yland	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, Lie Ms	ae	17. Father's Name (First, Middle, Last Abraham Marshall '	Taylor	p.		Beulah	ne (First, Middle, Ma H. Rounds		
Baltimore, Maryland	and dealth om 27		19a. Informant's Name/Relationship (Clarence young/huse) 20a. Method of Disposition	sband	105 (Gunby St.	, Snow H	ill, MD 2	City or Town, State, Zi 1863 Oc. Location - City or T	Transcription of the Control of the
Itimor	t. Pa rtmer rtant:		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fune) al Service Lices	5) [Mt. Zion (matory`or other plac Cemetery 2. Name and Addres	1/10	/04	Snow Hill,	MD
Ba	Depa Impo eny is		23a. Part1. Enter the disease, or com	X	L	ewis N. W	atson Fu	neral Home isbury, Mi or respiratory arres		Approximate
}	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	consequence of):					Interval Between Onset and Death
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α,	Se 75 9	by	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.		accoluse contribute to	
of Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of 2 No
of Vita	g Physician: The string of this certificate bral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y			er: 4 🗌 Nursing F	ath (Check only one) dome 5 Residen 28d. Describe how	nce 6 Other (Spec	(fy)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not t 4 Homicide determined	on Die Diese of Injury	r - At home, farm, st	M 1 🗆	Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
_	Hospital 24 hours a Funeral C	edical Ce		hysician: To the best of eminer: On the basis of eminer state	xamination and/or in					
	To the within 24 To the 8 complete	Med	29b. Signature and title of certifier	wednes ha	4.	29c. Licens	0 1 0		d. Date signed (Month	Day, Year)
D	Q		30. Name and address of person who		th (Item 23a) (Type,	Print) 400 £.	shole	Or. SAL	isbury.	MO
4	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 2 2	32. Registrar's	s Signature	Spark	2			

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213-22-6424

			For State Registrar		State	of Mar	yland / [irtment <i>tificate</i>				ental Hy	giene Reg. No	200	4	02	082
			1. Decedent's Name	(First, Middle, La	st)	-							2. Date of De	ath			3. Time of	Death
	Physicia /Medic				r Sabin		amson						Januar		, 2004		3:30	РМ
	Examin	er	4a. Facility Name (If								kevi]			40	. County of D Montg		Y*17	
		z ^k	5. Social Security No	ighton D		-	In yrs. last bir	thday)	If Under		If Under	24 Hrs.	8. Date of Bir	rth	9.1	Birthola	ace (State o	or Foreign
	Funeral Director		579-05-		1□M 2√2F	, ,		Yrs.	Months	Days	Hours	Min.	JULY) <u>_</u>	Count	y) yland	
9	ס		Usual Residence of 10a. State	Decedent 10b. County		1	0c. City, Tow	!-	antion							10	ld. Inside Ci	in Limite
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	28a-1	Director	10e. Street and Nun		CL y		BLOOK		10f. Zip	Code				10g. Ci	tizen of What	Count	ry?	
	3a or		1700 Bri		m Road				208	333				USA				
	death	Funeral	11. Marital Status	0	12. Was Dec		er in U.S.	13.			ispanic Or	igin? (Spe	ocify Yes or No Rican, etc.)		14. Race - A Black, W			
စ္က	hours after death with the Maryland ture!', or Items 23a or 28a-1 show al Exeminer must be restiffed at	y Fu		ed 2 Married	1 ☐ Yes If Yes, G	2 XNo					Specify:		110411, 010.)		Specify:		White	
Ö	hours turel',	d by	3 Widowed	4 Divorced 15. Decedent's E	Year or I	Dates:	162	Decer	lent's Usua	LOccup	ation			16b k	(ind of Busine			
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ם	al Hy	Bec	17. Father's Name)								(First, Middle		n Sumame)			
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Mar	12 sh h and 7 Is rr traur		19a. Informant's Na		• • • • • • • • • • • • • • • • • • • •				g Address Winar				i Route Numb ndalls	-		e, <i>21</i> 0 (
ف	1 and Heali tem 2		Mark Eme 20a. Method of Disp		end		20b. Place o					Tel. 7	ate	_	ocation - City			
ē	Pages ent of nt: If I		1 ☐ Burial 2 ☐	XCremation 3 [5 ☐ Other (Speci	□Removal from fy)	n State	Metro					1-29	-04	Ва	1timor	e,	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturely, or Items 23a or 28a-1 show any injury or other traumatic event, It a Medical Examinat must be mailted at ance.		21. Signature of u	u rod a.	SIA	 		22	Name and	d Addres	ss of Facili	iy Lety	of MD,	Inc		,	4.000	
	40244	ili li	23a. Part1. Enter the shock, or hea	ard A G	pegorer	11 K caused th	ne death. Do		/99 F1	reae	rick.	KOAG	Kal	T 7 MO	re, MD		1228 Approximat	ie
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ğ	w require been sig should b		One	brova	cula	2 0	ase	02	<u></u>				1 🗆	Yes 2	2□No 3□] Proba	ibly 4XQ	Unknown
ecc	law re as be	Completed											24a. Was	psy	24b. Were	autop to con	sy findings	available ause of
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ot	Phys r this ral dii	1: To	1 ☐ Yes 2 👿 27. Manner of Deat		28a. Date	e of Injury	2 ☐ ER/O	Time of		8c. Injur Wor	4 LI N		me 5 Res 28d. Describe			specify,	1	
ion	nding ith. :: Afte e fune	atlor	1 Matural 2 ☐ Accident	5 Pending investigation	1	onth, Day	Year)	Injury	М		k? Yes 2.[No No						
Division of Vital Records,	or Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	289. Piac	ce of Injury ding, etc.	y - At home, fa (Specify)	arm, str	eet, factory	, office			28f. Location City or To	(Street a	nd Number or te)	Rural	Route Num	iber,
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerat Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	edical Ce	29a. Certifier (Check only	1 Certifying P	hysician: To the	he best of	my knowledg	e, deatl	n occurred a	at the tin	ne, date a	nd place,	and due to the	cause(:	s) and manne	r as sta	ated. the cause(;	s)
	thin 24	Medi	one) 29b. Signature and			inner state			-		e number				ate signed (M			
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	20		30. Name and addr							r n	hoo±		D 200	00				
	St	ate	31. Date filed (Mor	ilotra,		Registrar	Georgi 's Signature	a AV	venue	W	heato	on, M	D 2090	JZ				
	Regist			JA	N 292	004	s Signature	w .	D. A	A STATE OF THE PARTY OF THE PAR	Star B							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:12 A M Robert Lee Amigh January 24 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Timonium Baltimore Stella Maris Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Yrs. March 28 1943 Pennsylvania **Director** 207-32-2683 60 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County •how other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No 28a-f MD Anne Arundel Laurel Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 7 North Carol Street 20724 USA or items 23a death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 【 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Trucking 12th Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Curtis Lee Amigh Anne Ferruzza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Amigh/Wife 7 North Carol Street, Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
eny injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory Jan. 27 2004 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses G35Kn 313 Talbott Avenue, Laurel, MD 20707 M00770 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUNG CANCER resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exam Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4⊡Pregnant at time of death 5 Other (specify) ☐Yes 2 No been signed by the a should be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 1 Yes 2 No 1 Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division After Hospitel or Attending 5 Pending uspiter ~ 4 hours after dee... 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined within 24 hours after de:

To the Funerel Directo

completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 3

State Registrar

10

DHMH 17 Rev 1/2001

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

JAN 2 9 2004

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month 22, 2004 John January 2:45am Vincent Aspromonte 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Homewood @ Crumland Farms Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jul 15, 1923 5. Social Security Number 9. Birthplace (Stete or Foreign Country) New York Months Deys Hours **¾**□M 2□ F 090-12-0129 80 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21702 8127 Stone Ridge Drive U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 1941— If Yes, Give Yeer or Detes: 1946 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marine Firefighter/Captain Public Safety/FDNY 12 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) John Aspromonte Rose UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Mary J. Aspromonte/Wife 8127 Stone Ridge Dr, Frederick, Maryland 21702 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete n Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery Jan 24, 2003 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Pensee 22. Name end Address of Facility Keeney & Basford P.A. Funeral Home 23a. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dyirig, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. M00706 106 East Church St, Frederick, Maryland 21701 Immediate Cause (Final disease or condition resulting in death) Que to (or es e consequence of): Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part il. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 No UITal 1 Tes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Physician/Medical Examiner Records, P.O. Completed by of Vital Be Medical Certification: To al or Attending Pt s after death. I Director: After th Division

Physicians as: VIncen

Physician

/Medical

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Maryland 21215-0020

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in and 2 should be file ont of Health and Mental Hyo

Physician

/Medical Examiner

> 25. Was case referred to medical examiner? 27. Menner of Death

5 Pending investigation 1 ⊠Natural 2 ☐ Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

The Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) January 23, 2004

30. Name and address of person who completed cause of reath (Item 23a) yp a rint)

Casper E. Crine, III, M.D., 300 West Ninth Street, Frederick, Maryland 21701

State Registrar 32. Regist s Signature

31. Date filed (Month, Day, Year) 2004

To the within 2

12

			For State Registrar	State of Ma	ryland				lealth a Death	ind M		giene Reg. No	2 U U	4	02085
			1. Decedent's Name (First, Middle, L	•							2. Date of De Month	ath Da	y Yea		3. Time of Death
	Physici /Medio		Dolores M.	Aquilino							01	16	•		5:00P M
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City	, Town, or	Location of	f Death		40	. County of De	ath	
			Calvert Count						Fred				Calver		
	Funeral		Social Security Number 6.	1□M 2ŪF		st birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da				ce (State or Foreign
	Director		577-60-1492 Usual Residence of Decedent	- X 9	2	113.	İ		1		6/5/1	1	Wa	shi	ngton,DC
	land ow		10a. State 10b. County		10c. City,	Town or Lo	ocation							100	I. Inside City Limits
	Mary	ţ	Maryland Calv	ert.	Pri	nce I	Fred	eric	k						XXYes 2 □ No
	r 28s	irec	10e. Street and Number				10f. Z	p Code				10g. Ci	tizen of What	Country	/?
	23a o	a D	140 Main St.				20	678						US/	4
	dea	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?	er in U.S	13.	Was Dece	dent of H	ispanic Orig	gin? (Sp., Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ar Black, Wi		
9	or It	by Funeral Director	1 Never Married 2 Married		lo		1 🗆 Yes		Specify:				Specify: W	hit	ce
21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Ad other than "natural", or Items 23e or 28e-f ahow event, the Medical Examinar must be notified at	q p	3.☐.Widowed 4 ☐ Divorced			16a. Dece	dont's He	al Occup	ation			16h K	(ind of Busines	se/Indu	etny
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an	id be ental ked (To Be	William Apple	ton Cady					Mary	М.	Munde	e11			
Maryland	s 1 and 2 should if Health and Men item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Addres	s (Street	and Numbe	r or Run	al Route Numb	er, City	or Town, State	, Zip C	ode)
	alth a		Michael D. Pa	xson/Gran	dson	140	0 Ma	in S	St. P	rin	ce Fre	eder	cick, M	D.2	20678
ē,	s 1 an of Heal item 2 other		20a. Method of Disposition	CD	20b. Pla	ace of Dispo	osition (Na matory or	me of other plac	ce)		Date		ocation - City		
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of			27. Manner of Death	28a. Date of Inju (Month, Da	ry v Year)	28b. Time o	of	28c. Injur Wor	y at		28d. Describe	how inju	iry occurred		
Ö	₩ ~ ₹ ž	atio	1 Natural 5 Pending 2 Accident investigat		, , , , ,	,,	М		Yes 2 □	No					
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	To the h within 24 To the F	Medi	one)	and manner sta	ited.		10	Do Liagno	se number			204 D	ato signed /M	nth O	v Vaari
	To To con	2	29b. Signature and title of certifier	41 0				D263			1		ate signed (Mo 7 / 200		ay, 1001/
•			Jet 14	Neight,	WD			J Z 0 3	, , , ,			1 / 1	7,200	7	
1	(0	1	30. Name and address of person with	e.				- -					75.		
	Ψ		John H. Weig 31. Date filed (Month, Day, Year)	el, M. D. 1		So.				unk	irk,MD	.20	/54		
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			For State Registrar	State of Maryland		artment of		nd Ment	al Hygie Reg.	/	4 02086
>	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) ELSE 4a. Facility Name (If not institution, give ste Anne Arundel Med			ADA M 4b. City, Town, Annapo	_	N (ate of Death lonth	Day Year 4c. County of Oeal Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Yea Months Day	r If Under 2	Min. 8. D. 6	ate of Birth Apnth, Day, Ye	0.8:-	thplace (State or Foreign buntry) Shington, DC
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland narment of Health and Mental Hyglene. ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Exem. In must be notified at injury or other traumatic event, the Medical Exem. In must be notified at 9.	by Funeral Director	Maryland Anne A: 10e. Street and Number 220 Spruce Ave.	rundel Ma	yo	10f. Zip Code	2110			Citizen of What Co	
9000	hours after deal	ed by Funer	11. Marital Status 1 Never Married 2 Married XXWidowed 4 Divorced 15. Decedent's Educi	2. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of If Yes, specify Cu 1 Yes 2 N dent's Usual Occ	o Specify:	jin? (Specify) Puerto Ricar		14. Race - Ame Black, Whit Specify: W	he, etc. Thite
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Baltimore,	permit. Pages 1 a Department of Hei Important: If item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	emoval from State 20b. Plac cem Kal	as C	Alexis estion (Name of matory or other p Cremato 2. Name and Ado	ry .	1/19/0)4 Ed	. Location - City of Igewater Funeral	
%	Physician /Medical Examiner		23a. Pent 1. Enter the disease, or combile shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequer	Do not en	1973 So ter the mode of d	lomons	S IS. cardiac or res	Rd. E	dgewate	r , Md . 21037 Approximate Interval Between Onset and Death
3760,	ite be executed sysician and he burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last		nce of):	515 EMA	R		UNE		2 DAS > 10 YS
.O. Box 68	that the death certificate ed by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	dc. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3[□Ectopic pregnar □ Other (specify)				23d. Date of de Month	livery Day Year
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Division of V	ding Phys h. After this funeral did	cation: To B	27. Manne Death 1 ** atural 5 Dending investigation	28a. Date of Injury (Month, Day Year)	NOutpatie 8b. Time o Injury	of 28c. in V	liury at Vork? □ Yes 2 □ I	28d.	Describe how	e 6 Other (Spe	
Divis	Hospital or 4 hours afte Funeral Dir ely filled in I	ical Certification:	(Check only 2 Medical Exemin	28e. Place of Injury - At hom building, etc. (Specify) iction: To the best of my knowled the control of the basis of examination	edge, deal	th occurred at the	time, date an	d place, and c	City or Town, S	State) se(s) and manner a	
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7	St Regis	ate	30. Name and address of person who co	mpleted cause of death (Item 2	104	Print) UE	elt	NE	An	WIEL	is, MD.

		4	For State Registrar	S	State o	f Mary	land /	-	artment rtificate				lental Hy	giene Reg. No.	21111	+ 0	208	87
	Physici	30	1. Decedent's Name (First, Midd	le, Last)									2. Date of Do	Day			e of Dea	
	Physicia /Medic	al -	Shiela M.						44 (2)4.	Taum 04	Location	of Dooth	1	20	2004 County of Dea		15p	М
	Examin	er	4a. Fecility Name (If not institution 833 W. Pratt			Apt.	711			ltim		Ji Death		10.	NA	401		ļ
	Funeral		5. Social Security Number	6. Sex			yrs. last t	birthday)		1 Year	If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth		rthplace (Sta	ite or Fo	reign
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	pu *		Usuel Residence of Decedent 10a. State 10b. Count	v		10	c. City, To	wn or Lo	ocation							10d. Insid	e City Li	imits
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	death with the Maryland ma 23a or 28a-f ehow r must be notified at	aiD	833 W. Prati	: Stre	eet i	Apt.	711		2.	1201					USA			
	r deal	Funeral	11. Marital Status	12.	Armed Fo		r in U.S.	13.	Was Deced	lent of Hi	spanic Or n, Mexicai	igin? (Spen, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh		n,	
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	i	1 ☐ Yes If Yes, Gi Year or □	ve			1 🗆 Yes	2 ∏ No	Specity:				Specify:	Black		
21215-0036	2 hour	ted t	15. Decede	nt's Educat	tion		16	Sa. Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Business	s/Industry		
215	e. e. Medi	Completed	(Specify only high Elementary/Secondary (0-12)		College (1-4or 5+)		life.	kind of wor DO NOT us	se retired)	N OF WORK	arg					
2	led wi ygien her th		5th grade	(004)				Do	mesti	c	19 Moth	ar's Name	e (First, Middle		er Peo	ple Ho	mes	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural," or itama 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event.	To Be	17. Father's Name (First, Middle Henry	, Lasi)		Wil	liams	5				ola	5 (1 1131, 1411GGA		ottley			
lary	2 shou and M ie mar aumat		19a. Informant's Name/Relation	ship (Type	, Print)		19							_	r Town, State,		_	
ა დ	l and lealth im 27 har tr		Dan Williams 20a. Method of Disposition		Son	13	20h Place		9 Pari		St.,	-	usta,		30904 ocation - City o		A	
סב	ages nt of h :: if ite		1 ☑ Burial 2 ☐ Cremation	3 □Ren	noval from		ceme	tery, cre	matory or o	ther place	1	1-31			•			
Baltimore,	artme ortant injury		* 4 Donation 5 □ Other 21. Signature of Funeral Service				NOEL		ew Cer 2. Name an	American					rence, e, Md.	2120	2	
æ	Depa Impo any i		b le o	lup	W	me	2	ě	March	r.F	I. Ea	st	11	Ol E	. North			
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complica	cause on	each line.			-					arrest,			imate Betwee and Deat	
P	Physician		Immediate Cause (Final disease or condition	a	MYC	CAI	20	IAL		NF	ARC	TIC	NC			301		
	/Medical Examiner		resulting in death)		Due to	(or as a co	onsequenc	ce of):	ART					-		5 Y 6	-0 p	
		e.	Sequentially list conditions, if any, leading to immediate	b		(or as a co		7 F	HZI	CK.	7 -	213	EAS) (THE	>
	d d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1														
ó	ate be executed hysician and he burial-transit	Еха	resulting in death) Last		Due to	(or as a co	onsequenc	ce of):										
68760,	physic the b	dicai		d														
9 X	certifi ding use as	/Me	IF FEMALE: 23b, Was decedent pregnant	230		itcome of p									23d. Date of d	elivery		
. Box	death e atte	iciai	in the past 12 months?			birth 2 [nant at tim			□Ectopic pr □ Other (sp						Month	Day	Year	r
P.O.	that the death certifica ed by the attending ph detached for use as th	Phys	9 Unknown	**				- i- th			an in Dard		220 Did	tobassa	ise contribute	to the cause	of deat	h2
ds,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	Part II. Other significant cond	bst	-			1	ON4~	-				Yes 2			Unkr	
Vital Records,	v requ been shoul	letec	<u> </u>				1		(1			24a. Wa	s an	24b. Were a	autopsy findi	ngs ava	ılable
Re	The law ate has page 2:	duio											aut	opsy formed?	prior to death?	completion	of cause	e of
ita		0	25. Was case referred to medi	al							26. Plac	e of Deat	h (Check only			20.10		
	Phyaician: r this certific ral director,	To B	examiner? 1 Yes 2 □ No	Но	spital: 1 🗆	Inpatient			ent 3 DC	the State of	4 🗆 14	ursing Ho			6 □Other (Sp	ecify)		
o uc	ing P		27. Manner of Death 1 XNatural 5 ☐ Pen	ding	28a. Date (Moi	of Injury oth, Day Y	ear) 288	b. Time o	of 2 M	28c. Injun Worl	yat k? Yes 2.⊑	No	28d. Describe	how injui	y occurred			
Division of	Attending r death. actor: After by the fune	icat	3 Suicide 6 Cou		28e. Plac	e of Injury	- At home,	, farm, st	treet, factor	-171	163 2	1140			id Number or I	Rural Route	Number,	
οį	al or A	Certification:	4 Homicide dete	rmined	build	ding, etc. (Specity)			,,			City or To	own, State)			
	To the Hospital or Attending Phys within 24 hours after deathTo the Funaral Diractor: After this completely filled in by the funeral di	edical C	29a. Certifier 1 Certifier (Check only one)	ring Physic al Examine	er: On the	e best of n basis of ex nner stated	amination	dge, dea and/or in	th occurred nvestigation	at the tin i, in my o	ne, date a pinion, de	nd place, ath occur	and due to the	e cause(s) e, date and	and manner a d place, and du	as stated. Le to the cau	ise(s)	
	To the within To the	Me	29b. Signature and title of cert	ier							e number				te signed (Moi			
			12/52	2	- ' \	W				000	052	941	0	JAI	1 2=	7 20	006	7
	H			hah,	MD		821	N. S	, Print) EUtal	NS	1 #	407	Bal	tion	0×2 N	102	120	
43	St Regist	ate rar	31. Date filed (Month, Day, Ye	JAN 2		Registrar's	Signature	Sant 1	IR D	hart	2)							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** anco /Medical c. County of Deeth 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Marylano 5. Social Security Number 8 Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours Min. 2,4-40-8662 60 Director man Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10a. State 10b. County 1XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Pages 1 and 2 should be filed within 72 hours after death with 27 is marked other than "natural", or Itame 23s or traumatic event, the Medical Examiner must be . 2/217 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 □ Yes 2 📉 No Baltimore. Maryland 21215-0036 10 acr 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Important of Health and Mental Hygiene.
Importent: if item 27 is marked other than "n any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) With a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maude 2 0 mes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type, Print) Brya N. 233 Trivia daughter 20b. Place of Disposition 20a. Method of Disposition 20c. Location - Dity or Town, State crematory or other place 1 Burial 2 Cremation 3 Removal from State 3 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nancy 21. Signate e of Funeral Service Licenses Ru al 3405 w. Franklin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death piratory Physician disease or condition resulting in death) /Medical Due to (a as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a co Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): as the burialthe attending physician hed for use as the buria P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year 5 Other (specify) detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 4 Dunknown 1 Yes 2 No 3 Probably been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 Yes 2 100 1 Yes ector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 1 Dinpatient 3 DOA After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: , c_mpletely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 Registrar

			For State Registrar	State of Maryland		artment of H			iene _{g. No.} 2	004	02089
36			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		G. Vir	ginia Brown				Januar	y 26,	2004	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. Co	unty of Deet	h
			Greater Baltim			Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Bal	timor	
	Funeral		5. Social Security Number 6. Security Number 10. Security Number 1	7. Age (In yrs. le	Yrs.	Months Days	Hours Min.	May 12.			hplace (State or Foreign buntry) ryland
	Director		Usual Residence of Decedent					Tray 12,	1910	, 110	
	death with the Maryland ms 23a or 28a-1 show r must be rediffed at	. [10a. State 10b. County		, Town or Lo						10d. Inside City Limits 1√3Yes 2 ☐ No
:	Sa-1 s	ctol	Maryland N/	A	Ba1	timore					
7	or 28	Funeral Director	10e. Street and Number	G . 1		10f. Zip Code	01011	1	0g. Citizen	n of What Co	ountry?
:	s 23a	ral	1433 Weldon Place	South 12. Was Decedent Ever in U.	S 13 V	Was Decedent of H	21211	necify Yes or No-	14.	USA Race - Ame	erican Indian,
	ltam.	nne	11, Marital Status 1 Never Married x2 Married	Armed Forces?	3.	Was Decedent of Hi I Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		Black, Whit	
و ا	al', or	by	3 Widowed 4 Divorced	1 ☐ Yes → 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes X2X☐ No	Specity:		Sp	pecify:	white
21212-0030	be filed within 72 hours after death with the Marylan Hydjone. Hydjone. do ther than "natural", or Itams 23a or 28a-1 show event, the Micrical Examinating and event, the Micrical Examinating and event.	ted	15. Decedent's Edu (Specify only highest grad	cation e completed	16a. Deced	dent's Usual Occupa	ation during most of work	kina	16b. Kind	of Business	/Industry
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)		0.	1 0	
N	e filed within al Hygiene. I other than vent, I'le Mis	ပ္	9th		Secr	etary	10 Mathor's Nor	ne (First, Middle, I		il Com	pany
=	tal H d oth	Be	17. Father's Name (First, Middle, Last) John Frederick She	ridan				Estella			
7	should be tind Mental to marked or umatic even	2	19a, Informant's Name/Relationship (T)		19h Mailir	ng Address (Street					Zin Code)
	~ ~ ~ ~		Dawn V. Anderson	Daughter		W. 43rd					
_	of Health of Health item 27 other tr		20a Method of Disposition	20b. P	 In facilities (All Annual Per L. Annual Per L. 	esition (Name of matory or other place	and the second s	-			Town, State
Baltimore,	permit. Pages 1 s Department of He Important: If Item any injury or oth		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)					/2004	Pike	esvill	e, Maryland
	artme oortar injur		21. Signatur of meral Service Ligens	and the second of the second o	00	Nome and Address	co of English				
ñ	Ped July Sun		Caux H	assenty	2 B	urgee-Hen 631 Falls er the mode of dyin	ss-Seitz	Funeral	Home	Inc	nd 21211
10 to			23a. Part1 Enter the disease or comp shock, or heart failure. List only o	lications that caused the death	n. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	iai y ia	Interval permeen
	Physician		Immediate Cause (Final disease or condition	Sepsis							Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequ	uence of):						
1 36	Examiner	L	Sequentially list conditions,	b	ment of						
	ed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	adrice ory.						
	xecut and al-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):						
209	ite be executed sysician and he burial-transit	calE		d							
687	ificate g phy: as the			-							
Вох	eath certificate attending phy I for use as the	M/U	23b. was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Feta	ncy I death 3	Ectopic pregnancy	,		230	d. Date of de	
	deat death	sicla	in the past 12 months? 1 □ Yes 2 No	4☐Pregnant at time of de		Other (specify)				Month	Day Year
<u>О</u> .	that the de led by the a detached f	Physician/Med	9 Unknown Part II. Other significant conditions co	established to dooth but not rock	ulting in the u	underhing eauen au	en in Part I	23e Did to	hacco use	contribute t	o the cause of death?
	The law requires that the death certifical to has been signed by the attending phyage 2 should be detached for use as the	þ	Part II. Other significant conditions of	inthoding to death out not resi	aiding in the d	indenialid canse die	en in roll.		es 2 🗆 1		robably 4 Unknown
0.0	requi	Completed						24a. Was a			•••
Vital Records,	e law has t je 2 s	I du						autops perfor	sy med?	death?	utopsy findings available completion of cause of
a			25 M				OS Plane of Dog	1 🗆 Yəs	2 No	1 🗆 Yes	s 2□ No
		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 -	ER/Outpaties	nt 3 DOA Oth	000	ath <i>(Check only or</i> lome 5 \to Resid		Other (So)	acify)
o	Phys or this oral di	J: To	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe h			
Division of	nding Ith. :: Afte e func	atloi	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □No				
Vis	actor by th	iffica	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, larm, st	reet, lactory, office		28I. Location (S City or Tow	treet and N n, State)	vumber or R	ural Route Number,
ā	tal or	Certification:									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina	wledge, deat tion and/or in	th occurred at the time timestigation, in my control of the timestigation, in my control of the timestigation.	me, date and place pinion, death occu	e, and due to the coursed at the time, d	ause(s) an late and pl	id manner a lace, and du	s stated. e to the cause(s)
	the hin 2, tha fundamental than fundamen	Medical	one)	and manner stated.		29c. Licens	se number		29d. Date s	signed (Mon	th, Day, Year)
	7 × 5 0	-	29b. Signature and title of certifier	- W 110			0248			-	
•	1		of Cyuran		n 23al /Tuno		- 0 1 0	N		4 - 0	2004 MD 21204
	19		30. Name and address of person who a	enawalt. MD	(17)	OI North	Charles	Street	Balton	rove	MD 21204
70	St	ate	31. Date liled (Month, Day, Year)	32. Registrar's Signa	ature	R. P.					
	Regist	FOR	1011 2 0 2004	All Barton and All		Sec.					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar Unpend Item#23 1. Decedent's Name (First, Middle, Last)			Bradford		2. Date of De. Month		Yeer	3. Time of Death
an al	Ti janne					January		, 2004	13:31
er	4a. Fecility Name (If not institution, give s St. Agnes Hospita	al			imore			NA	
	219-67-4503	7. Age (In yrs	last birthday) Yrs.	Months Days 3 13	If Under 24 Hr Hours Mir		y, Year)	Co	nplace (State or Foreig untry) Id .
	Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limit
tor	Md NA	E	Baltimo	re					1 X Yes 2 □ N
irec	Md NA 10e. Street and Number			10f. Zip Code			-	en of What Co	untry?
alD	618 Allendale St	•		212				USA	
/ Funeral Director	1 Never Married 2 Married	12. Was Decedent Ever in the Armed Forces? 1 Yes 27 No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 Yes 27 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		4. Rece - Amer Black, White Specify: Bla	e, etc.
d by	3 Widowed 4 Divorced	Year or Dates:							
Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	160. Kin	d of Business/l	industry
ф	Elementary/Secondary (0-12) Infant	College (1-4or 5+)		nfant	,		N	A	
Be C	17. Father's Name (First, Middle, Last)		1		18. Mother's Na	ame (First, Middle,	Maiden S	Sumame)	
To B	Rickey	Bradfo	ord		Deni	se		White	9
Ī	19a. Informant's Name/Relationship (Ty			ng Address (Street					
	Carolyn Hines	Grandmother		Allendal	le Stree	-			21229
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		cemetery, cre	osition (Name of matory or other plac		Date		ation - City or	
	*4 □ Demation 45 □ Other (Specify)	G		int Cem.	-	1-04	Balt	imore,	
	21. Sonature of Funeral Service Licens	00 11 /2 / Agre /	2	2. Name and Addre				e, Md.	21202
	23a. Pa 1 Enter the disease, or compl	wavey j	ub. Do not on	March F.				lorth A	Ve. Approximate
ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clisease of injury that initiated events resulting in death) Last	Due to (or as a conse							
dicai		d							
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fer 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnancy □ Other (specify) _	y		23	3d. Date of deli Month	very Day Year
by Ph	Part II. Other significent conditions co	ntributing to death but not re	sulting in the u	ınderlying cause giv	ven in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
						10'	Yes 2	No 3□Pro	obably 4 Unkno
									topsy findings availal completion of cause of
omplet					26. Place of D	eath (Check only o			
0	25. Was case referred to medical			0#	ner: 4 🗆 Nursina	Home 5 Resi	denc <i>e</i> 6	Other (Spec	cify)
o Be	examiner?	Hospital: 1 ☐ Inpatient 2	XER/Outpatie	nt 3 DOA			how injury	occurred	
ToB	examiner? 1 Yes 2 □ No 27. Manner of Death	1 ∐ Inpatient 20	28b. Time o	of 28c. Injui	ry at	28d. Describe I			C-11
To Be	examiner? 1 Yes 2 No	28a. Dale of Injury (Month Day Year) 1/26/04 28e. Place of Injury - At huilding atc / Soer	28b. Time of 12:30	of 28c. Injui	ry at	sleeping	Street and	Number or Ru	ral Route Number,
Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Phy	28a. Date of Injury (Month Day Year) 1/26/04	28b. Time of 12:30 home, farm, strify)	of 28c. Injure Wor p M 1 reet, factory, office	ry at rk? Yes 2 No me, date and pla	sleeping 28f. Location (c. City or Tol. 401 Col.) ce, and due to the	Street and yn, State) Leen S cause(s) a	Number or Ru treet, Ba	ral Route Number, ltimore, MD stated.
To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medicel Exami	28a. Date of Injury - At building, etc. (Specification of my kind at 10 me.)	28b. Time of 12:30 home, farm, strify)	of 28c. Injure Wor p M 1 reet, factory, office	ry at rk? Yes 🏖 No me, date and pla ppinion, death oc	sleeping 28f. Location (c. City or Tol. 401 Col.) ce, and due to the	Street and yn, State) Leen S cause(s) a date and j	Number or Ru treet, Ba	1timore,MD stated. to the cause(s)
edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Phy one)	28a. Date of Injury 1/26/04 28e. Place of Injury - At building etc. (Spec Found at home sician: To the best of my kiner: On the basis of examinand manner stated.	28b. Time of 12:30 home, farm, standard farm, stand	p M 1 post in the strength of the occurred at the trivestigation, in my company 29c. Licens	ry at rk? Yes 🏖 No me, date and pla ppinion, death oc	sleeping 28f. Location (401 Col.) ce, and due to the curred at the time,	Street and wn, State) Leen S cause(s) a date and p	Number or Ru treet, Ba and manner as place, and due	nral Route Number, 1timore, MD stated. to the cause(s) h, Day, Year)

		_	= For Amend Item #8 pe		land / De 04 tas C	partment of ertificate o	Health and Marketh for the second sec	Mental Hygie	ene 200	4 02091
	Physicia	an	1. Decedent's Name (First, Middle, Last, Middle, Last, BER					2. Date of Death Month	Day Yea	3. Time of Death 1230 AM
	/Medic Examin	er	4a. Fedility Name (If not institution, give Howald Co. Go. 5. Social Security Number 6. Se	street and number) ENERAL Ke x 7. Age (Ir	sp. In L	Colo	ar If Under 24 Hrs.	70	4c. County of De	
	Director	}	027-28-6952 1D]M 2∏F	82 Yrs.	Months Day	S Hours Will.	March 3	1921 Yu	goslavia
	Maryland f show		10a. State 10b. County MD Howard	10	c. City, Town or Colum				ı	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	or 28e-	Director	10e. Street and Number		00141	10f. Zip Code	9	10	g. Citizen of Whet	Country?
	1234 c	ralD	7110 Minstrel Wa				21045		USA	- incorporation
336	72 hours after deeth with the Maryland natural; or items 23a or 28e-f show dical Examiner in wat be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	r in U.S.	3. Was Decedent of If Yes, specify Control of Italian Specify Control of I	f Hispanic Origin? (Sjuban, Mexican, Puerti Bo Specify:	Decity Yes or No- Di Rican, etc.)	Black, Wi	nerican Indian, nite, etc. White
21215-0036	rithin 72 houne. ne. han "nature e Modical E	Completed	15. Decedent's Edu (Specify only highest grad	le completed) College (1-4or 5+)	(G.	e. DO NOT use ret	ne during most of wor	king	8b. Kind of Busines	
d 22	filed w Hygie other ti		12th 17. Father's Name (First, Middle, Last)	Ø		Iomemaker	18. Mother's Nam	e (First, Middle, Ma	OWn : aiden Sumame)	Home
a a	fental fental rked o	To Be	Unknown				Unkno	wn		
Maryland	2 should and he he man		19a. Informant's Name/Relationship (T)				et and Number or Ru			
altimore, I	permil. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other treumatic event, the Macical Exemitment must be notified at ance.		William G. Berkso 20a. Method of Disposition 1 X Burial 2 Cremation 3 Cl 4 Donation 5 Other (Specify,	Removal from State	20b. Place of Dis cemetery, o	14 Black sposition (Name of crematory or other p 1 Cemeter	olace)	Date 2004 I	Oc. Location - City	or Town, State
Baltir	permil. F Departme Importar eny injur		21. Signature of Funeral Service Ligens	600	0160		dress of Facility Do	naldson F	uneral H	ome, P.A.
	Obveision		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.			tying, such as cardiad		st,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a co	onsequence of):	<i></i>	- 7777	Eq.		
o,	cate be executed physicien and the burial-transit	Examiner	Sequentially fat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	eoint.	estina	Blz	eding		
8760,	cate be	dical		d						
.O. Box 6	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic pregna 5 □ Other (specify)			23d. Date of o	delivery Day Year
Δ.	quires that t n signed by uld be deta	by P	Part II. Other significent conditions co	ontributing to death but n	not resulting in th	e underlying cause	given in Part I.			to the cause of death? Probably 4 XUnknown
I Records,	- m	Completed						24a. Was an autopsy perform	ed? prior t	
Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:	44.0		Othor	th (Check only one		
of	fune fune	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2 SER/Outpa 28b. Tim lnju	e of 28c. Ir	4 Nursing H	ome 5 Resider 28d. Describe how		oecify)
Division	et or Attandi s after death. st Director: A st in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (At home, farm, Specify)	, street, factory, offi	СӨ	28f. Location (Stre City or Town,		Rural Route Number,
V	To the Hospitet or At within 24 hours after of To the Funerel Direct completely filled in by	edical (ysician: To the best of n liner: On the basis of ex and manner stated	amination and/o					
)	To the within To the comp	Me	29b. Signature and title of certifier	each m	0		onse number		d. Date signed (Mo	
	10		30. Name and address of person who	CHOWA!		pe, Print)	ERAL No	sp. Cir.	lumbia	ms 21044
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	L.				

ORIGINAL

			1 - For State Registrar	State of Marylar		artmen <i>rtificat</i>			and M		giene Reg. No. 4	2004	020	92
	Dhysisi		1. Decedent's Name (First, Middle, Last							Date of De. Month	ath Day	Yeer	3. Time of E	Death
	Physici /Medio		ELIZABETH ANN	BROWN						Januar		2004		A ^M
	Examir		4a. Fecility Name (If not institution, give			4b. City,	Town, or	Location o	f Death			ounty of Deeth		
		W.	3707 Donnelle Dr:		forma de instruction el	+	restv 1 Year	ville If Under:		8. Date of Birt		ince Ge	orge's	Foreign
	Funeral Director		0. 000	7. Age (In yrs. M 25 F 90	Yrs.	Months	Days	Hours	Min.	Oct.24,	y, Year)	Cou	ranna Co	
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation							10d. Inside City	Limits
	Mary	to	Maryland Prince G	eorge's Fo	restvi	11e							1 🛭 Yes	2 🗌 No
	r 288	by Funeral Director	10e. Street and Number			10f, Zip	Code				10g. Citize	on of What Cou	untry?	
	th with	a D	3707 Donnelle Dri	ve, Apt #203		2	0747				U.S.	.A.		
	r dea	Iner	11. Maritat Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	- 14	 Race - Amer Black, White 		
36	or it	y F	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 🗆 Yes	2 C No	Specify:			s	pecify: B1	ack	
ö	hours lural	d be	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a Daca	dent's Usua	at Occupa	tion			16h Kind	of Business/l	ndustry	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Exami mericust be notified at	Completed	(Specify only highest grad	e completed)	(Give	kind of wo	rk done a	luring most	of working	ng	TOD. KING	10: 20311033/1	naastry	
12	with iene. ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Clea	aning	Supe	rvisc	or		D.C.	Gover	nment	
D	Hyg other	Be C	17. Father's Name (First, Middle, Last)							(First, Middle,				
<u>a</u>	lid be lental rked ic ev	To B	Fountain Bland					Eliz	zabet	h Wood	son			
Maryland	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show may injury or other traumatic event, the Medical Example in must be notified at once.		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	i Route Numbe	er, City or 1	Town, State, Z.	ip Code)	
Σ	and 2 latth a		Ronald T. Brown/C					Road	l, Fo	rt Was	hingt	on, MD	20744	
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	1 .	Place of Disponentery, cre-	osition (Nar matory or o	ne of ther place	9)	D	ate	20c. Loca	ation - City or 1	Town, State	
ij	Peg ment ant: h		'4 □Donation 5 □ Other (Specify)	Fo	rt Lin	coln	Ceme	tery	01/3	1/2004	Brent	twood.	Marylan	ıd
alt	permit. Departr Imports any inj		21. Signature of Funeral Service Licens	•		2. Name an				L HOME				
<u> </u>	8979		Nancy A.	Vercon be	3	<u>401 B</u>	lade	nsbur	g Ro	ad, Bre		od, Mar	yland 2	
г			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.					cardiac o	r respiratory ai	rest,		Approximate Interval Betw Onset and D	een
	Physician		fmmediate Cause (Final disease or condition	Acute Myocar	dial I	nfarc	tion						011001 4110 5	
y .	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):									
¢,	LAMINICI	-		b. Due to (or se a conesc	scanners offe									
	ed sit	Examiner	it any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Dae to for the medical	eranica ory.									
	xecul and	хап	that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):									
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687	ificate g phy as the			u.										
Вох	death certificat e attending phy d for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		□Feterie e					23	d. Date of deli-	very	
	0 0 0	icla	in the past 12 months? 1 ☐ Yes 2 🏖 No	1 Live birth 2 Feta		⊒Ectopic pi ⊒ Other (s¢						Month	Day Y	ear
P.0	at the de by the	hys	9 ☐ Unknown	9□ Unknown										
S, F	The law requires that the tte has been signed by thoage 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not res	sulting in the L	underlying o	ause give	n in Part I.					the cause of de	
ord	w require been sig									10	res 2 🗠	No 3∏Pro	obably 4 □Ui	nknown
Record	e law re has be	ompleted								24a. Was autop		prior to c	topsy findings a omptetion of ca	vailable use of
Ä	The ate has page	Com									rmed?	death? 1 ☐ Yes		
Vital	sician: T certificat rector, pa	Be (25. Was case referred to medical examiner?						of Death	(Check only o	ne)			
of V	\$ w 0	2	1 ☐ Yes 2 🖾 No		ER/Outpatie			4 🗆 INU		ne 51X Resid			ify)	
ů		on:	27. Manner of Death 1 ☒ Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work			28d. Describe i	now infury	occurred		
Division	e at S	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Discontinuo Atlanta		M		Yes 2 1		201 1	Ca-a-a-a-a-a-a-a-a-a-a-a-a-a-a-a-a-a-a-	North and Co.	and Oncode Alcomb	
Ξ	or Attendate death Director:	THE STATE OF	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, tarm, st fy)	reet, factor	y, office		-	City or Tox		Number or Hui	rai Route Numb	167,
	Hospitel or 4 hours afte Funsrel Dir tely filled in		29a. Certifier 1€ Certifying Phy	eicien: To the best of muke	nwledge dest	th necurred	at the tim	ne date en	d place of	and due to the	cause(s) o	nd manner or	stated	
×	Hos 24 hc Fun etely	edical	(Check only 2 Medical Exam	sician: To the best of my kn- iner: On the basis of examina and manner stated.	ation and/or in	rvestigation	, in my of	oinion, deal	th occurre	ed at the time,	date and p	lace, and due	to the cause(s)	
,	To the Hospitel or Atte within 24 hours after de To the Funsrel Directo completely filled in by th	Me	29b. Signature and title of gentlier			290	c. License	number			29d. Date	signed (Month	, Dey, Year)	
)	⊢ ≶ ⊢ ŏ		Mulman				D-00'	55120			Janu	ary 28	, 2004	
	'n		30. Name and address of person who c	ompleted cause of death (fte	m 23a) (Type,							_		
	U		Richard Palmer,				ue, #	[‡] 310,	Wasl	nington	, D.C	J		
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's sign	ature	y A	PA AS							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 24, 2004 **Physician** JÄNÜARY 10:30 A M BEGELMAN DORIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB.7,1918 9. Birthplace (State or Foreign Country)
ENGLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2 F 85 060-10-6670 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or Iteme 23e or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🕅 No BETHESDA Funeral Director MD MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 5550 TUCKERMAN LANE 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE ρ 3 ₩ Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY** HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WOODMAN FANNIE MAX 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 MCCORMICK ROAD ROCKVILLE, MD HARVEY STROMBERG / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Important: If ther
eny injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🛱 Removal from State ETERNAL LIGHT MEMORIAL 1/25/2004 BOYNTON BEACH, FL ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur yra Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Spect W 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS seven days /Medical Due to (or as a consequence of): Examiner fneumonia Seven days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ut as a consequence of): Examine attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Parkinsons disease 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has lirector, page 2 s autopsy performed egosman 2) No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. January 24, 2004 Rockville P.Ke, 11125 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Westerman Pockuille, I wiked 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 18N 2 9 2004

ORIGINAL

			For 1 - State Registrar	State of Maryla	nd / Depa			lental Hy	giene Reg. No. 20	04 02095
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last Lawrence 4a. Facility Name (If not institution, give				Sr. or Location of Death	2. Date of Dea Month	Day 7 20 20 4c. County 0	
	Funeral Director		210 37 7/37	7. Age (In yrs	. /ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da JULY 29	h y, _{Year)} 9 1939	Birthplace (State or Foreign Country) NC
	death with the Maryland ms 23a or 28e-f show	tor	Usual Residence of Decedent		ity, Town or Lo	cation STATION				10d. Inside City Limits 1 ☐Yes 2 ☐ No
	with the 3a or 28	il Direc	10e. Street and Number 230 CHESTNUT STRE	ET		10f. Zip Code	21222		10g. Citizen of W	hat Country? USA
)36	be filed within 72 hours after death with the Marylan Ital Hyglene. d other than "netural", or flems 23a or 28e-f show event, the Madical Express, must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, k, White, etc. BLACK
Maryland 21215-0036	within 72 houene. ene. than "neture the wedical E	Completed	15. Decedent's Edition of the Company of the Company of the Company (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire LIFT OPE	during most of work ad)	sing	16b. Kind of But	
yland 2		To Be C	17. Father's Name (First, Middle, Last) DENNIS LEE BURDEN	-			18. Mother's Nam	HELMA WI	Maiden Sumame HITTED	a)
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 Is marke any injury or other traumatic 0000.		19a. Informant's Name/Relationship (T. REBECCA GOLDSTEIN 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licenses)	Removal from State M	Place of Dispo cemetery, crer	O CHESTN sition (Name of matery or other plate). Name and Addr	1/31	ALTO., No Date /04 MES A. N	D 21222 20c. Location - O BALTO., MORTON &	City or Town, State MD SONS F.H., INC
760,	w requires that the death certificate be executed we signed by the attending physician and should be detached for use as the burial-transit	ilcal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of interest of the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	blications that caused the decone cause on each line. a. End 540 Due to (or as a consect of the consect of the cause on each line. Due to (or as a consect of the consec	age negative of the sequence o	Renal			rrest,	Approximate Interval Between Onset and Death
O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnand Other (specify)	су		23d. Date Mon	e of delivery hth Day Year
rds, P.	quires that t an signed by uld be detar	ed by Ph	Part II. Other significent conditions co	ontributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records, P.O. Box	: The law re cate has bee ; page 2 sho	Completed						1 X Yes	rmed? d 2□No 1	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 No
Z Z	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3□ DOA O	26. Place of Dea ther: 4 ☐ Nursing H		one) dence 6 □Othe	er (Specify)
ion o	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time o Injury	W	uryat ork? ⊡Yes 2⊡No	28d. Describe	how injury occurre	ed
Divis	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filted in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory, office		28f. Location (: City or Tox		er or Rural Route Number,
	he Hospi n 24 hou he Funer oletely fill	Medical	29a. Certifying Ph (Check only 2 Medicel Exemone)	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	date and place, a	and due to the cause(s)
)	To ti withi To ti	Σ	29b. Signature and title of certifier	M.D.		P	17954		1/26	(Month, Day, Year)
	NO		30. Name and address of person who	completed cause of death (It	em 23a) (Type,	AUD NI	ve, Bal	Hmore	M/) 2	1224
		ate rar	31. Date filed (Month, Day, Year) JAN 2 9 200	32. Registrar's Sig		Lower		, -,	,	

				For State Registrar	State of Mary	land / De	partment of Fertificate of	Health and M		giene 20	04 02096
				Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	3. Time of Death
_		Physicia		HELEN	MARIE		BAKE	0	Month	Day	Year 21-26M
		/Medic		4a. Facility Name (If not institution, give				or Location of Death	IAM	23 °4 '	
	4	Examin	er	· · · · · · · · · · · · · · · · · · ·							L FOND
				5. Social Security Number 6. S		yrs. last birthda		If Under 24 Hrs.	8 Date of Bir		
	н	Funeral		4	_M 28ΩF // Λ98 ()"/		Months Davs	Hours Min.	8. Date of Bir (Month, Da	1024	9. Birthplace (State or Foreign Country)
		Director		212-30-2330 Superior State of December 1		69 Yrs.			May 22	, 1934	Maryland
		land		10a. State 10b. County	100	c. City, Town or	Location				10d. Inside City Limits
		Many f she	ō	Marriand Harriand	,	Fores	L TT: 11				1 ☐ Yes 2X No
		with the Maryland a or 28a-f show be notified at	Director	Maryland Harford 10e. Street and Number		rores	t Hill 10f. Zip Code			10g. Citizen of W	/hat Country?
		with	Ö	2528 Sandy Hook	Poad		210	250			
		within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must by molified at	Funeral	11. Marital Status	12. Was Decedent Ever	in II S 1			ecify Ves or No		SA - American Indian,
		er de	n n	1 ☐ Never Married 2 ☐ Married	Amed Forces?	11 0.3.	 Was Decedent of F If Yes, specify Cub. 	an, Mexican, Puerto	Rican, etc.)	Blac	k, White, etc.
	36	s aft	by F	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify	White
	5-0036	72 hours "natural", dical Exe	De L	15. Decedent's Ed		16a Do	cedent's Usual Occup	nation		16b. Kind of Bu	sinoss/Industry
-0		n 72	ete	(Specify only highest gra	de completed)	(Gi	ve kind of work done DO NOT use retire	during most of work	ing	100. Kind of bu	siness/industry
8	121	f within 72 ho jene. r than "natu the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemaker	۵,		Orm 1	Tomo
. 0	121	-		17. Father's Name (First, Middle, Last)			TOTICHAREL	18. Mother's Name	a (First, Middle	Own]	
X	land	ould be filed with Mental Hygiene. arked other than atic avent, the	Be	Lester Howard	Mahaffoy				Pearl		-7
3	Ē	s should be filed withir and Mental Hygiene. Is marked other than aumatic avent, The Mental Aumatic avent.	ပ္	19a. Informant's Name/Relationship (1		10h M	uling Address (Street	1			State Zin Code)
	Maryl	d 2 should be filed th and Mental Hyg 7 Is marked othe traumatic avent,		Donna S. Baker /	• • • • • • • • • • • • • • • • • • • •		28 Sandy H				
		s 1 and 2 if Health itam 27 I othar tra		20a. Method of Disposition					Date		City or Town, State
5	ō			1 ☑ Burial 2 ☐ Cremation 3 ☐			position (Name of rematory or other place				
1	Baltimore	permit. Pages Department of Important: If i any injury or one		4 □ Donation 5 □ Other (Specify	12.7 . TT. TT. TT. TT. TT.	Hartord					en, Maryland
3	3a	permit Depar Impor any in		21. Signiture of Funeral Service Licen	see]		22. Name and Addre	ess of Facility Tuneral Ho	me, P.A	A.	
0	ш_	<u>v</u> ∪ = e o	1 17	Jaku 11 Cema	1 Rennyt		50 W. Bro	padway, Be	l Air,	MD 2101	4
				23a. Part 1. Enter the disease, or comp shock, or hear failure. List only	plications that caused the one cause on each line.	death. Do not e	enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
		Pnysician	8 17	Immediate Cause (Final disease or condition	HAS	(11)					Onset and Death
	1	/Medical		resulting in death)	Due to (or as a co						
	п	Examiner		a construction of the cons	b						
			Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	nsequence of):					
9		d d ansit	Examiner	Cause (Disease or injury	C						
0	ć	sician and burial-transit	Exa	resulting in death) Last	Due to (or as a cor	nsequence of):					
80	68760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	icai	(d.						
33	89	leath certificat attending phy I for use as th									
-	ŏ	ndin use	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr					23d. Date	of delivery
#	m	feath atte	cla	in the past 12 months? 1 ☐ Yes 2 ☑No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		3 □Ectopic pregnanc; 5 □ Other <i>(specify)</i> _	у		Mor	th Day Year
M	o.	at the de by the a stached	Physician/Med	9 Unknown	9□Unknown						
	σ.	res that igned b be deta	y P	Part II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use contr	bute to the cause of death?
	ds,	uires sigr Id be	d by	DIABETES	MERCITU	51481	7		1 🗆	Yes 2√ No	3 ☐ Probably 4 ☐ Unknown
	ecord	w requir been s should	ete	DIABETIC	NEPHRO 8	ATHY			24a. Was	an 24h W	Vere autopsy findings available
4	Rec	e lav has je 2	Completed						auto	osy pormed? d	rior to completion of cause of eath?
C	_			SP CARD	IAC PAC	EMAK	CER		1 ☐ Yes		Yes 25 No
+	Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Deat			
	of	등 도교	ို	1 No	1 L Inpatient		ient 3 DOA	4 LI Nursing Ho		dence 6 □Othe	
. ~		ding P h. After i funera	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time	Wor		28d. Describe	how injury occurre	Ð
2	sio	tand leath tor: /	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
V	Division	al or Attandir s after death. I Diractor: Af d in by the fur	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, pecify)	street, factory, office		28f. Location (: City or To	Street and Numbe wn, State)	er or Rural Route Number,
2		spital or Attan ours after deat ieral Diractor: filled in by the									
20	V	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exen	ysicien: To the best of my niner: On the basis of exa	y knowledge, de mination and/or	ath occurred at the tire investigation, in my o	me, date and place, opinion, death occurr	and due to the ed at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
9	1	To tha Hos within 24 h To tha Fun completely	Med	one)	and manner stated.		29c. Licens				(Month, Day, Year)
		To To Con		29b. Signature and title of certifier	1 4						
		a.		mama		4.D		21809		JANZ	3,2004
		**************************************		30 Name and address of person who		(Item 23a) (Typ		A A T	111110 - 1	1.) 144	0 21093
				31. Date filed (Month, Day, Year)	32. Agistrar's S	3 5 L	YOAK	100	, , -1, 0, 10	10 10	0 41043.
		Sta Registr		1AN 2 9 20			Section 1				

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month James Stanley Brush January 26, 2004 3:30 AM 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 3166 Tucker Road Street Harford 8. Date of Birth (Month, Dey, Yeer)
NOV. 28, 1918 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Days Hours NDM 2DF 220-03-1883 85 Maryland Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Street 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3166 Tucker Road 21154 **USA** 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 ∑XYes 2 ☐ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Machinest Steel Manufacturer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James (unk) Brus Stella (unk) Zielinska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) <u>Eileen W. Brush / Wife</u> 3166 Tucker Rd., Street, Maryland 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-28-04 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
MCCOMAS Funeral Home, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chear failure. List only one cause on eech line. 50 W. Broadway St., Bel Air, Maryland 21014 Immediate Cause (Final disease or condition resulting in death) TRANSFORMED LYMPHOMA 6MONTH 4 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? EMPHYSEMA 1 Tes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No

28c. Injury et Work?

15 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

1 TYes 2 No

D45530

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

ettending physician and

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Diréctor

Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23s or 28s-f show

Depertment of Health and I Important: If Item 27 Is ma

6

any injury o

Baltimore, Maryland 21215-0020

Director: / filled in by

Physician/Medical Examiner þ Be Completed Certification: To

or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760,

within 24 hours a
To the Funeral D
complataly filled edicai 3

death.

State Registrar

SWASAILAN 31. Date filed (Month, Day, Year) JAN 2 9 2004

5 Pending

investigetion

6 Could not be determined

27. Manner of Deeth

Naturel 2 Accident

3 Suicide

29a. Certifier

4 I Homicide

(Check only one)

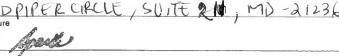
29b. Signature and title of certifier



ann

rall

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)



M

28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

DHMH 16 Rev 6/95

			1 _ For	State of Maryland /	Depa		lealth and Me	ental Hygie	ne 200	Ng nangg
		_	Registrar	A)	Cei	uncate of t		Reg. 2. Date of Death	No.	02030
	Physici /Medi		Decedent's Name (First, Middle, Las George (nmn)	Bawtinhimer				Month JANGAR		2014 314 AM
	Examir	ner	4a. Facility Name (If not institution, give				r Location of Death		4c. County of De	eeth
			144 Fairmount			Bel				rford
	Funeral Director		074-12-9799	7. Age (In yrs. last b 7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Yes) Peb. 11,		Birthplace (State or Foreign Country) BNADA
	pu 🖈		Usuel Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	sho	<u>_</u>								1 Yes 2 No
	Sa-1	ecto	Maryland Harfor	d Be	1 A					
	vith t	Ö	10e. Street and Number			10f. Zip Code		10g.	Citizen of What (Country?
	s 23c	Funeral Director	144 Fairmount Dr		1.0	210			USA	
	er de	une	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of H f Yes, sp <i>eci</i> fy Cuba	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Hace - An Black, Wi	nerican Indian, hite, etc.
36	or or	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: WW∏ ፲		I□Yes 2√kNo	Specify:		Specify:	
215-0036	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show dissi Evantrat must be rolified at	pe	15. Decedent's Ed		a Doore	lost's Usual Ossua	ation	101	Kind of Business	White
5	"na"	Completed	(Specify only highest grade)	de completed)	(Give	lent's Usual Occupi kind of work done o	ation during most of working f)	7	o. Kind of Busines	ss/industry
12	filed within Hygiene. ther then "	E	Elementary/Secondary (0-12)	College (1-4or 5+)			"		0-16	
121	Hygie ther nt,		17. Father's Name (First, Middle, Last)		_Sa.	Lesman	18. Mother's Name /	First Middle Mai	Golf	
au	ntal ed o	Be		awtinhimer						
Ž	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ms	2	19a. Informant's Name/Relationship (7		b Mailin	= Addass /Street	Helen	(nmn)	(unk)	7.0.7.1
Maryland	12 si h an 7 Is r fraur						and Number or Rural	- SANTAGORAN CANAGO	ty or lown, State	, ZIP Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinet must be notified at ance.		Ruth Bawtinhimer / 20a. Method of Disposition		144	Fairmoun sition (Name of	t Dr., Bel		21014	T
Baltimore,	Pages nent of thint: If its		1 Burial 2 Cremation 3	comet	ery, cren	natory or other plac	:6)	10 200	. Location - City of	or rown, State
Ë	permit. Page Department of Important: If any injury or once.		*4 □ Donation 5 □ Other (Specify				orp. 1-27-		wson, Ma	ryland
Sali	Departi Departi Imports any inj once.		21. Signature of Funeral Service Licen	300	22 N	ICCOMAS F	s of Facility Hom	e, P.A.		
=	40 E # 9		sulle ul	Recely	1 5	0 W. Bro	adway, Bel	Air. Ma	ryland 2	21014
r			23a. Part . Errer the disease, or comp shock, or heart failure. List only	lications that caused the death. Do one Fluse on each line.	not enti	er the mode of dyin	g, such as cardiac or	respiratory arrest,	-50	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Misorandi	0	Part.	· · · · · · · · · · · · · · · · · · ·			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	ol):	garen	,			
	Examiner		Constitution for the first	· a teringele	when	a Cond	contest.	las de	Laenie.	
	35. 752	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):					
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Examiner	that initiated events	c						
ó	exection and and arrigal-tr	EX	resulting in death) Last	Due to (or as a consequence	of):					
760,	le be ex /sician e burial	cai		d						
89	leath certificate I attending physical I for use as the t	Physician/Medic								
Вох	ndin	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					23d. Date of d	elivery
	that the death cer ed by the attendir detached for use	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	the or	Jys	9 Unknown	9□ Unknown						
	res that signed b	y P	Part II. Other significant conditions co	ntributing to death but not resulting	in the ur	derlying cause give	en in Part I.	23e. Did tobacc	co use contribute	to the cause of death?
Sp.	uires sigr ld be	d by	Dialetes					1 🗆 Yes	2 No 3 F	Probably 4 Liunknown
Ö	w requir been si should	Completed	(0 D. D.	1)				24a. Was an	0.45 114	
žé	has has	E C	- Wyreiner	Verlage				autopsy performed	prior to	autopsy findings available completion of cause of
=	cate							1 ☐ Yes 2 ☐		as 2 🕅 No
Ž	iician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death (
of Vital Records,	this aldi	၉	1 M 162 5 100	1 Inpatient 2 ER/O			4 Nursing Home			pecify)
Ę	ding f	lon	27. Manner of Death 1 ■ Natural 5 □ Pending		Time of Injury	28c. Injury Work		d. Describe how in	njury occurred	
Division	Vitsndi death. ctor: A y the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Ξ	irec	Ē	4 Homicide determined	28e. Place of Injury - At home, 1 building, etc. (Specify)	arm, stre	eet, factory, office	28	 Location (Street City or Town, St 	t and Number or F tate)	Rural Route Number,
	rat D									
	tosp t hou fune	cai	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☑ Medical Exam	sician: To the best of my knowledginer: On the basis of examination a	je, death nd/or inv	occurred at the time	ne, date and place, an pinion, death occurred	d due to the cause	e(s) and manner a	as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	oney	and manner stated.						
	To To	2	29b. Signature and title of certifier	7		29c. License	number	29d.	Date signed (Mor	nth, Day, Year)
	U		Bernard 1. 4 de	Ana MO, DNE		D00/4	4206	Na	Marine	25, 200 4
	101,			completed cause of death (Item 23a)	(Туре, І	Print)	*	1	/	
_	1,			KNA MO, ONE	70	118 HOLA.	BIRA AVE	BALTON	nd 212	೩೩
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	S. Sand	and I				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Day Yeer **Physician** Jan Yary 23, 2004 /Medical 4b. City, Town, or Location of Death 4a. F acility Name (If not institution, give street and number) **Examiner** Hupkins 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8 MUOS 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☐ M 25€ F Director 213-78-5098 March27,1960 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or itams 23a or 28a-f show edical Ezaminar must be notified at 1 X Yes 2 □ No Directo Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Way 21224 .S.A. 6224 Shipview filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ۵ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working
 life. DD NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Disable 10th n/a permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked othery injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Buckson Sr. Elaine Fowlkes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Fowlkes/mother 2012 Ramblewood Rd. Apt. D Balto. MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Jan29,2004Baltimore,MD * 4 ☐ Donation 5 ☐ Other (Specify) KingMemorialPark 21. Signature of Funeral Service Deensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO. MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition dweeks **Physician** /Medical resulting in death) **Examiner** immunodeficiency Syndrome Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Hinknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 ☐Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending within 24 hours after useau...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)-AMIN SABET, MD 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 9 2004

ORIGINAL

heila Ch	ri	stian . For	State of Ma	arylan	d / Depa		t of H	ealth a		lental Hy	giene	nni.	02100
Physici /Medic		Registrar Antalu Ttalifr Sp. Decedent's Name (First, Middle, Las Shella Renee	" Chris						of Dogsth	2. Date of De Month Januar	Day y 25 20	Year 004	3. Time of Death
Examir Funeral	ner	4a. Facility Name (If not institution, give 923 Seagull Aven 5. Social Security Number 6. St. 215-84-4474	ue	e (In yrs. 1	ast birthday) Yrs.		I 1 Year	Balti Balti II Under Hours	more	8. Date of Birt (Month, Da	N/A h y, Year)	9. Birth	place (State or Foreign
Director		Usual Residence of Decedent 10a. State 10b. County	- M 2-X		/, Town or Lo	ocation				DEC 7,	1961		y Land 10d. Inside City Limits
the Marylar 28a-f show	Director	Maryland N/A		Bal	Ltimor	e 10f. Zij	Code				10g. Citizen o	f What Cou	1 X Yes 2 □ No
3 or	0	923 Seagull Avenu	ie			21	225				USA		
ie; will yiell with a first of the field within 72 hours after death with the Maryland I hauth and Mental Hygiene. It hauth and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-1 show other traumatic event, the Modical Evanimer russ be notified at	by Funerai	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:		1	Was Dece If Yes, spe 1 Yes		ispanic Ori n, Mexicar Specify:	gin? (Spi i, Puerto	ecify Yes or No Rican, etc.)	- 14. Ri Bi	ace - Americack, White,	
hin 72 hou an "natura" Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation	5+)		DO NOT u	se retired)			16b. Kind of	_	dustry
od with	Con		2		Certi	fied	Medi				Hospi		
should be filed within nd Mental Hygiene. I marked other than umatic event, the M	To Be	17. Father's Name (First, Middle, Last) Douglas Gerald Ch		Sr.						e (First, Middle, Jean Per		ame)	
2 sho and lame		19a. Informant's Name/Relationship (al Route Numbe			
Pages 1 and 3 nent of Health out: If Item 27 ury or other tr		Joi Dorothea Christian 20a. Method of Disposition 1 Burial 2 X Cremation 3 C	Removal from State	20b. P	1 4/1 Place of Dispo emetery, creating tro Cr	osition (Na matory or	me of other plac	e)		Date	altimor 20c. Location Baltim	- City or T	own, State
parmit. Pages 1 an Department of Heal importent: If item 2 any injury or other once.		*4 □ Donation 5 □ Other (Specification 21. Signature of Fundral Service Licer	Fy M	<u>-</u> '		2. Name a	nd Addres	ss of Eacili	y iety	of MD	Inc.		
Physician		23a. Part 1. Enter the disease, or conditions shock, or heart failure. List only Immediate Cause (Final disease or condition	resorchik plications that cause one cause on each li	d the deat	h. Do not en	ter the mo	de of dyin		cardiac	or respiratory a	Ltimore rrest,	, MD	21228 Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (on as	a conseq	uence of):								
e be executed sicien and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as										
cords, F.O. BOX boloo, wrequires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ∑Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	⊒Ectopic p ⊒Other (s						Date of delive	ery Day Year
law requires that the as been signed by the 2 should be detached.	b	Part II. Other significant conditions of	contributing to death t	out not res	ulting in the u	underlying	cause giv	en in Part	l.	23e. Did t			the cause of death?
The lay	Completed											b. Were auto prior to co death?	opsy findings available ompletion of cause of
VICAL F iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth Oth	ar		h (Check only o			
O 문 등 열	10	1X Yes 2 □ No 27. Manner of Death	1 inpati	101	ER/Outpatie		UA _	4 🗆 N	ursing Ho	ome 5 ☐ Resi 28d. Describe			mat scene
Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	_ (Month, Da	ay Year)	ford 7	A M	28c. Injur Wor 1 🗍	k? Yes 2. ∑	No	subj	est an	autte	l
DIVISION I or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be determined	e 200 Place of le	jury - At h	ome, larm, st		ry, office			City or To	wn, State)		al Route Number.
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Plants Medical Exe	nysician: To the besi miner: On the basis of and manner s	of examina	owledge, dea	th occurre	d at the tir	me, date a ppinion, de	nd place, ath occur	and due to the	cause(s) and	manner as	stated.
To th within To th compl	Me	29b. Signature and title of certifier	enbon	NI	D	29	OCM]	e number E			29d. Date sig Janual		
か		30. Name and address of Green who Tasha 2 Green	hberz	MJ		Print)	11 P	enn S	tree	t, Balt	imore,	Mary	land 212 0 1
Si Regis	tate trar	31. Date liled (Month, Day, Year)	IAN 2 9 201	rar's Sign.	alife Listerio	, <i>B</i> .	4	ale .					

	4	For State		State of	Maryl	and / De	PATTY	t of a	ealth and	Mental Hy	/giene	2001	0010
Physician		State Registrar ATRON Decedent's Name (Fire	d Tter st, Middle, La	#20b po	er fh			e of L	Death	2. Date of De	Reg. No.		3. Time of Death
Physician /Medical		ARMAD				CLOUDE				JANUA		3, 2004	
Examiner	4	a. Facility Name (If not 18800 ROXB)	_		nber)			Town, or ERST	Location of De	ath		County of Dee ASHINGT	
Funeral	5	. Social Security Number			7. Age (In	yrs. last birthd	(V) If Under	r 1 Year	If Under 24 H				rthplece (State or Fore
Director		212-19-389	92	∑ M 2□ F	16	Yrs	Months	Days	Hours Mi	n. (Month, D.			Md.
D >	-	Jsual Residence of Dec	edent c. County		100	. City, Town or	Location						10d. Inside City Limi
the Marylar 28a-f show counts at		Md.	N.F	1	100	-	timore	9					Y Yes 2 N
uter death with the Mar r Itama 23e or 28e-f st the must be collined the rest Director	-	Oe, Street and Number					10f. Zip	Code			10g. Citi	izen of What C	country?
3a or		2029 Robb	St.					21218	3		US	A	
death	1	1. Marital Status		12. Was Dece Armed For	dent Ever	in U.S. 1	3. Was Dece	dent of Hi	ispanic Origin?	(Specify Yes or Ne erto Rican, etc.)	0-	14. Race - Am Black, Wh	
		1 Never Married 3 □ Widowed 4 □		1 Tes If Yes, Giv Year or Da	² ₩No		1 Tes		Specify:				Black
ed within 72 hours a vgiene. 1. The Medical Exact. Completed by			Decedent's E	ducation ade completed)		16a. De	cedent's Usu	al Occupa ork done d	ation during most of v f)	vorking	16b. K	ind of Business	s/Industry
within and the man		Elementary/Secondary	y (0-12)	College (1	-4or 5+)		e bonori Never V					NA	
al Hygiene." I other than " went, the Me		8th grade 17. Father's Name <i>(First</i>	, Middle, Lasi	')		1	VEVEL I	VOLKE		ame (First, Middle			
Mental H arked off atic ever		Frederic	ς		C	loude			Lily		M	orton	
2 should and Mis mar sumat		19a. Informant's Name/	Relationship	Type, Print)		19b. M	ailing Address	s (Street a	and Number or	Rural Route Numb	per, City o	or Town, State,	Zip Code)
ss 1 and 2 of Health a item 27 is cothar tra		Lily Mortor	<u>n</u>	Mother	-				. Balt:	imore, Mo	,	1218	
permit. Pages 1. Department of He Important: If iten any injury or oth once.	2	20a. Method of Dispositi 1 Donation 5 ☐	emation 3 [☐Removal from S		•	sposition (Na. crematory or d Iem. Pl	other plac	1/3	1/04 29-04		ocation - City o	r Town, State
permit. Pa Departmer Important Imp injury once.	T	21. Signature of Funera	Service Lice	nsee			22. Name a		ss of Facility	Bal		re, Md.	
90 E 2 9	1	23a. Part1. Enter the di	Lad	-	حمس		March					orth A	Approximate
Physician /Medical Examiner ie burial-transit cal Examiner		Immediate Cause (Fina disease or condition resulting in death) Sequentially list commit if any, leading to immediate. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last	(Due to (Due to (or as a cor	A AVI nsequence of): nsequence of):	BLUR	N Fo	PLE /L	JURIES	OK M	IE AD	Onset and Death
The law requires that the death certificate be exite has been signed by the attending physician age 2 should be detached for use as the buria completed by Physician/Medical E		IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 □ No 9 □ Unknown	ths?		irth 2 🗌 ant at time	Fetal death	3 □Ectopic p 5 □ Other (s _i					23d. Date of de Month	əlivəry Day Yəar
w requires that been signed b should be deta leter by Prieses.	7	Part II. Other significan	t conditions	contributing to de	eath but no	t resulting in th	e underlying (cause give	en in Part I.				to the cause of death? Probably 4 □Unkno
: The law requir cate has been s page 2 should										24a. Was auto perf 1 N Yes	opsy ormed?	prior to death?	autopsy findings availa completion of cause is 2 No
)	25. Was case referred t	o medical							eath (Check only			
this D	2	1 Yes 2□No				2 ER/Outpa		_	4 14013111	Home 5 Res			
Attending P or death. ector: After the type the funeral ification:		2 Accident	Pending investigation	on //23	oy Fas	ND 03	35 M	1 🗆	y at k? Yes 2 No	ASPHYX	IATE	-D AND	BEATEN
Hospital or Attending P 24 hours atter death. Funeral Director: After tely tilled in by the funeral lical Certification:		3 Suicide 6	Could not determined	buildi	of Injury - ng, etc. (S)	At home, farm pecify) ECTIONA	street, factor	y, office	CEIL	28f. Location City or To	(Street and State	nd Number or F D) 1880 Duni, m	Rural Route Number, O ROXBURY D
0 7 6 5	8			miner: On the ba			r investigation	n, in my o	pinion, death o	ice, and due to the curred at the time	, date and	d place, and du	e to the cause(s)
the Hospi in 24 hour the Funer pletely till					//		29		e number		29d. Da	te signed (Mor	ntn, Day, Year)
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely tilled in by the funeral Medical Certification:		29b. Signature and title	of pertifier	11	(has			(OCME		JAN	JUARY 2	4, 2004
To the Hosp within 24 hos within 24 hos roughletely the Completely the Medical		30. Name and address MANN 31. Date filed (Month, E	of person with	completed caus	e of death	1.	- 22			ltimore,			

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylai	nd / Depa <i>Cei</i>	artment of H	lealth and l		eg. No.	3, Time of Death
	Physici /Medio Examin	al -	Shirley Ja: 4a. Fecility Name (If not institution, give s 6412 Hawthorne Av	street and number)		4b. City, Town, or Elkrido	r Location of Deat	January	Day Y	9ear 4 5:17 P M
D	uneral irector		5. Social Security Number 214-38-4214 Usual Residence of Decedent	111 000	last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 24	Year) 9	Birthplace (State or Foreign Country) Maryland
d 21215-UU36 filed within 72 hours after death with the Maryland	Department or reatin and wenter rypenes. Department or reatin and wenter rypenes and properties or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	nerai Director	Maryland Howard 10e. Street and Number 6412 Hawthorne Aver	nue	ity, Town or Lo		ispanic Origin? (S			tates American Indian,
Z I Z I 3-0036 od within 72 hours after	n "natural", or ite legical Exertine	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece	T Yes, specify Cuba 1 ☐ Yes 2 ☑ No dent's Usual Occup kind of work done of DO NOT use retired	Specify: ation during most of wor		Specify:	White, etc. White
Maryland 212 d 2 should be filled withi	rked other ther tic event, tre M	To Be Comp	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Delbert W. Shafer	College (1-4or 5+)		Homemake	r 18. Mother's Nar	ne (First, Middle, I	,	Iome
ore, mary	or nealin and h fitsm 27 is me r other treuma		John R. Calton, Jr 20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Re	Spouse	6412	ng Address (Street a Hawthorne sition (Name of natory or other place	e Avenue	Elkrido		and 21075
baltimore,	Important: If any injury o		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License	Mea		Mem. Pa Name and Addres Ary L. Ka 250 Washi	1			Maryland P., Inc. aryland 21075
/N	ysician ledical aminer	1000	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Finaf disease or condition resulting in death)	cations that caused the dea e cause on each line. PARKING Due to (or as a consec	th. Do not ent					Approximate Interval Between Onset and Death
	ysician and ne burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
Attending Physician: The law requires that the death certificate be executed	igned by the attending pr be detached for use as the	by Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet: 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
he faw requires that	en signed by ould be deta		Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	\	te to the cause of death? Probably 4 □Unknown
Idi nov. en: The lawr	tificate has be tor, page 2 sh	e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was at autops perform 1 Yes 2	y prior ned? deat No 1 □	e autopsy findings available to completion of cause of h? Yes 2 \(\) No
Jor Attending Physician:	withing 42 flours are beaut. To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should	ation: To B	27. Manner of Death Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of fnjury (Month, Day Year)	ER/Outpatien 28b. Time of Infury	28c. injury Work	er: 4 🗆 Nursing H	ome Reside		Specify)
spital or Atte	ours aner de neral Directo filled in by th	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci ician: To the best of my know	fy) owledge, death	occurred at the tim	ne date and place	City or Town	, State)	r Rural Route Number,
To the Hos	To the Fur completely	Medical	(Check only 2 Medicel Examinone) 29b. Signatur, and title of certifier	er: On the basis of examination and manner stated.	ation and/or inv	/estigation, in my op	oinion, death occu	rred at the time, da	ate and place, and Od. Date signed (M	due to the cause(s)
D	5 Sta		30. Name and address of person who could be seen and address of person address of person and address of person address	mpleted cause of death (Itel	NOLL 1		CUNBIA,	W. 2	1045	
	Registr		JAN 2 9 200	- AC.	A STATE OF THE PARTY OF THE PAR	and I				

			1 - For State Registrar	State of Maryland	d / Department of H Certificate of L			6004	02103
			Decedent's Name (First, Middle, Last,)	~	2. D	Reg. I		3. Time of Death
н	Physici		1 ARRV 1	DARNELL	CARTER			Day Year 2 2cc4	10:35 AM
	/Medi Examir		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death		4c. County of Death	10.33
			ST. Agnes Hea	1th Care	Balti	more		N	IA
	Funeral		5. Social Security Number 6. Sec		Months Dave	If Under 24 Hrs. 8. D	ate of Birth Month, Day, Yea	9. Birthp	place (State or Foreign
	Director		010-19-1007	1M 2DF 42	Yrs. Volums Days	M	AV 25,	1961 MF	RULANL
	and *		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Location		/ /	1.	0d. Inside City Limits
	Aaryta Bho	៦	146.004.00	/ 0 .	12		7.71		12 Yes 2 No
	28a-1	ect	10e, Street and Number	114		MORE	-119	077	
	with	2	(27 d) A/ L	-111	10f. Zip Code	2.200	109.1	Citizen of What Cour	ntry?
	hours after death with the Maryland tural', or Itams 23a or 28a-f show all Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	S 13 Was Decedent of Hi	spanic Origin? (Spacety)	os or No-	14. Race - Americ	an Indian
10	fter d r ften iner	ᇤ	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🕅 No	If Yes, specify Cuba	spanic Origin? (Specify Y n, Mexican, Puerto Rican	, etc.)	Black, White,	
21215-0036	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔼 No	Specify:		Specify: 2	nav
Ò	72 ho	Completed	15. Decedent's Edu	cation	16a. Decedent's Usual Occupa	ation	16b.	Kind of Business/Inc	dustry
218	⊆ - 4	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired,	furing most of working)			
7	73 73 -	5	10 +HGRADE		MACHINE	E OPERAT	OR	FACTO.	RU
nd	be filed tal Hygi d other event,	Be (17. Father's Name (First, Middle, Last)	a		18. Mother's Name (Firs	t, Middle, Maide	en Sumame)	
Na Na	Mould by Ment	2	JOE	CAL	RTER	MAE		CLAI	RK
Maryland	2 sho and is m	1 59	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing Address (Street a	and Number or Rural Rou.	te Number, City	y or Town, State, Zip	Code)
-	1 and Health em 27		MONROE CLARK	(BROTHER)		LTON ST.	BALTI	MORE MI	5.21229
ore ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		ace of Disposition (Name of metery, crematory or other place	Date	20c.	Location - City or To	wn, State
Ë	-63		* 4 □ Donation 5 □ Other (Specify)	MI	: ZION CEMEN	ERY 01-29-0	04 LI	ANSOD and	EMD.
Baltimore	permit. Pag Department Important: It any injury o		21. Signature of Funeral Service Licerca	1	22. Name and Addres	s of acility BROW	WIR.	FUNERA	L HOME
<u> </u>	705 g g	. 57		10-0	- 2140 N.	FULTONI	AVE. B	ALTO, MI	21217
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. ne cause on each line.	Do not enter the mode of dying	g, such as cardiac or resp	iratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ALLITE RE	SPIRATORY D	ISTRESS S	YNDR	OME 3	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque					
			Sequentially list conditions,						
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):				
_	and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
8760,	cate be executed physician and the burial-transit			500 10 101 00 0 001100000	3100 01).				
387	cate ohys the	dical							
9 X	The law requires that the death certifics ate has been signed by the attending pt page 2 should be detached for use as it	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnan	cv				
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 Fetel of 4 Pregnant at time of dea	death 3 Ectopic pregnancy			23d. Date of delive Month	ry Day Year
P.O.	that the death ed by the atte detached for	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	The second of th				
	that the ed by detac		Part II. Other significant conditions cor	tributing to death but not result	ting in the underlying cause give	n in Part I. 2:	3e. Did tobacco	use contribute to the	e cause of death?
sp.	w requires that been signed to should be det	Completed by	DIABETES				1 🗆 Yes :	2 □ No 3 □ Proba	ably 4 Unknown
Ö	w req beer shou	lete					45 1465	045 11/2	
Re	The lav	m					4a. Was an autopsy performed?	prior to con death?	sy findings available apletion of cause of
a			25. Was case referred to medical				Yes 2□N		2 🗆 No
Ē	ysician: is certific director.	o Be	examiner?	ospital:	Othe	26. Place of Death (Che			-
Division of Vital Records,	Phys arthis aral dii); To	27. Manner of Death	28a. Date of Injury 2	PVOdipatient 3 DOA	4 Nursing Home 5	escribe how inj	_ ' ' ')
o	th. Th. Afte	itio	1, ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Work	? es 2 □ No		ary document	
/sl	Atter dea octor	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, street, factory, office	28f. Lo	cation (Street a	and Number or Rural	Route Number
á	afte Dire	Certification;	4 Homicide	building, etc. (Specify)		Cit	ty or Town, Sta	te)	
	To the Hospital or Attending Physician: which 24 hours after deals as a fer deals To the Funeral Director. After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	sician: To the best of my knowl	ledge, death occurred at the time	e, date and place, and du	e to the cause(s) and manner as sta	ated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medicel Examir one)	ner: On the basis of examination and manner stated.	on and/or investigation, in my opi	inion, death occurred at th	ne time, date ar	nd place, and due to	the cause(s)
	Veith To t com	Σ	29b. Signature and title of certifier		29c. License		29d. D	ate signed (Month, D	Pey, Year)
)	^		Bahra		P167	05	Ta	A 28,200	24
	(1)		30. Name and address of person who co	mpleted cause of death (Item 2				· - wy seece	
			Dr. Bahrus St. Age	ies Health Car	e, 900 Cuntan	Ave, Bal	timore	MD	
	Sta		on bato mod (memm, bay, roar,	32. Registrar's Signatu	re				
	Registr	ar	JAN 2 9 2004	Alistin Lo	6803462 V				

DHMH 17 Rev 1/2001

CARTER, CARRY

			Chats of Manufaced / Department of the				
			1- State of Maryland / Department of Heal Certificate of De			- / III la	02101
		- 7	1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death	No.	06.109
	Physici /Medic		Viola E. Couser		Month 25	Day Year	7, W A M
	Examin	er	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death		4c. County of Deet	n
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Year If I	Under 24 Hrs.	8. Date of Birth	1 V A	onlane (State or Foreign
	Funeral Director		212-36-1640 1 M 2 F 64 Yrs. Months Days H	Hours Min.	8. Date of Birth (Month, Day, Ye	39 co	nplace (State or Foreign untry)
	and *-		Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. tnside City Limits
	be ilied within 72 hours after death with the Maryland ital Hygiene. or other then "natural", or Itams 23a or 28e-f ehow event, the Medical Examinar must be notified at	ţo	MA AllA Briltimies				1 X Yes 2 □ No
	r 28e	irec	10e. Street and Number 10f. Zip Code		10g.	Citizen of Whal Co	untry?
	th with	Funeral Director	12924 W. Coldsoring Lane, 212	15		USA	
	r dea	ner	11. Maritat Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispat If Yes, specify Cuban, M	anic Origin? (Spec Mexican, Puerto R	cify Yes or No-	14. Race - Ame Black, White	
36	s afte , or it	by Fu	1 Never Married 2 Married 1 Yes 2 No Si	Specify:		Specify: 12	INOV
21215-0036	tural	edb	3 ☐ Widowed 4 Dovorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	n	166	b. Kind of Business/	HCA
215	within 72 ene. then na	Completed	(Specify only highest grade completed) (Give kind of work done durin Elementary/Secondary (0-12) College (1-4or 5+)	ng most of working	g	. /	1
21	filed wit Hygiene other the	Corr	10th GRADE NURSE			Haspi	<i>au</i>
Maryland	be fill d oth	Be	17. Father's Name (First, Middle, Last) 18.	. Mother's Name	(First, Middle, Maid	den Sumam)	
7	should be ind Mental imarked umatic ev	ဥ	19a. Informant's Name/Relationship (Type, Print). 19b. Mailing Address (Street and It	ineim	a Cak	CTER	- 0-7-1
Ma	2 2 2 3		Munito Bampons (Sister) 38XL C-PANE	AND An	Route Williams, Cl	Himmins State, 2	MD 21245
ē,	of Health Item 27 other tr	1	20a. Method of Disposition (Name of cemetery, crematory or other place)	Da	ite 20c	. Location - City or	Town, State
E	Pages nent of I unt: If Its ury or o		1 Donation 5 Other (Specify)	PON (1-25	X-04 F	altimo	re MD
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of	Fability Vau	ighnce	reener	ineral Seic
	2011		Nough Cyn 5151 gatte	U. Nat	YPIKE,	Batto.	MD 21229
В			shock, or heart failure. List only one cause on each line.	uch as cardiac or	respiratory arrest,		Approximate Intervat Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	pma			Two months
	Examiner		Due to (or as a consequence of):				E .
10		ler	Security in conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				
	cuted	Examiner	Cause (Disease or injury that initiated events c.				
760,	te be executed ysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):				
6876	cate b physic the b	dlcal	d				
9 X	death certificate I attending physi-	√/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delin	100
Box	death certifica e attending ph d for use as th	by Physician/Medi	1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)			Month Month	Day Year
P.0.	the by th ache	hys	9 □ Unknown				
	w requires that the s been signed by th should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.		o use contribute to	
ord	een s	ted			1. Yes	2 No 3 Pro	bably 4 Unknown
3ec	aw 1s b	Completed			24a. Was an autopsy performed	24b. Were aut	opsy findings available ompletion of cause of
al	ysician: The l is certificate ha director, page		25. Was case referred to medical		1□ Yes 2€	No 1 ☐ Yes	250 No
₹	Physician: this certific ral director,	To Be	examiner?	Place of Death	,	6 ☐Other (Spec	74.1
Jo C	g Phy ler thi		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		d. Describe how in		ry)
Sior	Attending r death. ector: After by the fune	atlo	2 Accident investigation M 1 Yes	2 🗆 No			
Division of Vital Records,	l or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	If. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
Ц	pitel ours a nerel [29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, do	tata and place, an	ed due to the server	(a) and	
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinior one)	on, death occurred	at the time, date	and place, and due	to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier 29c. License nun	mber	29d. I	Date signed (Month	Day, Year)
)			MMIMX IVIV D3	728	Jan	very 27	2004
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	· A	Y 22 1	24	nonson
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Significe 32. Registrar's Significant	~ IVIES	NE 24/	so linure	111021213
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signifure 32. Registrar's Signifure 33. Date filed (Month, Day, Year)				

*			For	State of Mary				Mental Hy	/giene	2001	0010
*	5		1 - State Registrar	_	Cei	tificate of	Death		Reg. No.	2004	UZIU
Ph	ysicia	an	1. Decedent's Name (First, Middle, Last)	Alle	1.	1 _ i1		2. Date of D Month	eath Day	Year	3. Time of Death
	Medic		4a. Facility Name (If not institution, give s	UTIVIQ	Camp		or Location of Death	01			1, 12 H-W
Ex	camin	er	11 m	. 1	lation	B.C.	- 111		46.	County of Death	
Fun	neral	-	5. Social Security Number 6. Sex		yrs last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birthp	place (State or Foreign
Dire			215-22-6155 10	M 200F	7 Yrs.	Months Days	Hours Min.	Month, D	ay, Year)	-6 Cour	ms
pud *	020		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ention					Od Jacida City J imin
Aaryle I sho	18 DB	ō	ws 11/1			1				'	0d. Inside City Limits 1 ☑Ýes 2 ☐ No
the N	and and	ect	10e. Street and Number	<i>t</i>	Balt	10f. Zip Code			10a Citi	izen of What Cour	-
with 3e or	97		4	Avenue		2	1715		rog. On	11 5 0	wy:
death	9	Funeral Director		2. Was Decedent Ever	in U.S. 13. V	Vas Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N	0-	14. Race - Americ	
after or Ite	and and	Fu	1 Never Married 2 Married	Armed Forces? 1 Yes 252 No If Yes, Give	1	Yes, specify Cub		Hican, etc.)		Black, White,	etc.
1d 21215-0036 a filed within 72 hours after death with the Maryland II Hygiene. other than "natural", or Items 23e or 28s-f show	Ex	d by	3 Widowed 4 □ Divorced	Year or Dates:	À	/				Specify: B	lack
15 n	Spa	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced	ent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Ki	nd of Business/Inc	dustry
d 2121 fited within Hygiene.	Thu N	E	IOTA Grade	College (1-4or 5+)		1/0-	K		Ra	Himore.	City
and	/ent	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	, Maiden		
arylan should be nd Mental	atic e	10 E	Jessie Min	205			Ed	Na	Bro	oo K	
lary 2 shoul and Me Is mark	eum eum		19a. Informant's Name/Relationship (Typ	ne, Print	19b. Mailin	g Address (Street	and Number or Run		er, City o	r Town, State, Zip	Code)
e, M 1 and 2 Health em 27 I	her tr		Lois Brinkley	(LNEICE	320		ntowst.	Baltin	rore,	mb. a	21216
timore, t. Pages 1 au tment of Hea	any injury or other treumatic event, the Medical Examiner must be nutified at once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re		MI -	natory or other plac	c e)	Jale	20c. Lo	cation - City or To	wn, State
Baltim permit. Pag Department Important:	njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	7	11/1- 210		ten 01-2	6-04	Ba	Himore	Mb
Balt permit. Departr Imports	eny i		Maria	Dass	1 5	ISI Rall	n Alahy	PIVA CI	2 11	600	21229
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the	death. Do not ente	or the mode of dyin	ng, such as cardiac	or respiratory a		עוזו ניט	Approximate
Physic	cian	8 8	Immediate Cause (Final disease or condition	Human	JO PART MARKET					111	Interval Between Onset and Death
/Med	licäl		resulting in death)	Due to (or as a cor		K DIO VASC	ular c	DISEASE			
Exam			Sequentially list conditions, b								
P	sit	iner	cause. Enter Underlying	Due to (or as a cor	Meguanda of)-						
and	l-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	seguence of):						
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and	burial-transit	icai E		000 10 (01 23 2 001	isoquonico cij.						
687 ificate p phys	2	edic	0								
Box eath certi	for use as	Z	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pr					2	3d. Date of delive	ry
death death	od for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐ 4☐Pregnant at time		Ectopic pregnancy Other (specify)	<u>'</u>				Day Year
P.O. nat the de	etach	Physician/Med	9 🗆 Unknown	9☐ Unknown		·					
Cords, P w requires that been signed b	pe o	þ	Part II. Other significant conditions con			derlying cause giv	en in Part I.			se contribute to the	
Orc requi	hould	eted	ALZHEIMERS	DEMIEN	IIA			1	Yes 2L	JNo 3∐Proba	ably 4 Minknown
Hec elaw has t	2	Completed						24a. Was auto	DSV	prior to con	sy findings available opletion of cause of
Vital F iiclan: Th certificate	director, page							1 Tes	•	death? 1 ☐ Yes	2 No
Sicial	irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	WED	Oth	26. Place of Death				
P & silling	eral d	. To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	2ER/Outpatient 28b. Time of	3∐ DOA 28c. Injun	er: 4 🗆 Nursing Ho	me 5∐ Resi 28d. Describe	dence 6 how injury	i ∐Other <i>(Specify,</i> coccurred)
Inding	unj e	atio	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	tr) Injury	Wor	k? Yes 2□No		, ,		
Division of Vital Records, I or Attending Physician: The law requires ti after death. Director: After this certificate has been signe	by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location (. City or To	Street and	l Number or Rural	Route Number,
ital of its after ral Di	led in					<u> </u>					
DIVISION of VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	iely fil	Medical	Check only 2 Medical Examin	cian: To the best of my er: On the basis of exar	knowledge, death nination and/or inv	occurred at the tin	ne, date and place, a pinion, death occurr	and due to the	cause(s)	and manner as sta	ited. the cause(s)
thin 2	eldmo	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				signed (Month, D	
1 × 1	8		N 1 1	1. D							
s		-	30. Name and address of person who cor		(Item 23a) (Type P	Print)	59107	L18601		18-20	MICHAG
	8					2 GROW	BALT	IMOR E	/ H	1.0 212	215
	Stat		31. Date filed (Month, Day, Year)	W ESTSIDE 32, Registrar's S 2 9 2004	icature	4	30		7		
	gistra		JAN	2 9 2004	A CONTRACT OF	or Appear			_		
DHMH 17 R	ev 1/20	01		-		*					

	•	1 - For State Registrar	State of Marylar	•		of Health and Moore	Reg	ene 200	4 02106
Physicia /Medic		Phyllis E	. CHappelle	7			2. Date of Death Month	Day Yeer	3. Time of Death 12:34 P M
Examin	er	4a. Facility Name (If not institution, git 1450 Bed Ford 5. Social Security Number 6.	ive street and number) AUC APT 2 Sex 7. Age (In yrs.	16	Pike.	wn, or Location of Death SVIIIC Year If Under 24 Hrs.		4c. County of Dea	nore
Funeral Director		178-34-3724 Usual Residence of Decedent	1 M 2 F	73 Yrs.		ays Hours Min.	(Month, Day,)	(ear) C	thplace (State or Foreign ountry)
a-f show	ctor	10a. State 10b. County MD BALF		ity, Town or Lo Les Vi					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
23a or 28 14al be no	ral Director	10e. Street and Number 1450 BedForce	1	16	101. Zip Co	208		g. Citizen of What C	
rel', or itame 23a or 28a-f ehow Exeminer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deceden If Yes, specify 1 ☐ Yes 2 【	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi	
Health and Mental Hygiene. em 27 is marked other then "naturel", or iteme 23s or 28s-f ehow ther traumatic event, the Madical Examinar must be notified at	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	DO NOT use r	lone during most of wor etired)	king	6b. Kind of Business Uashine ton	^
Department of Heatih and Mental Hygiene. Important: If item 27 is marked other then "natu eny injury or other traumatic event, Itra Madical once.	To Be Co	17. Father's Name (First, Middle, Las William La	COVES st)	1/401110	M RCS	18. Mother's Nam Helen	ne (First, Middle, Ma	aiden Sum al me)	D.C Schools
lealth and h m 27 is ma her trauma		19a. Informant's Name/Relationship	le / Daughter	4100	BedE	treet and Number or Ru	Himore,	mo 212	07
rtment of F rtant: If ite njury or ot		20a. Method of Disposition 1	□Removal from State	Place of Dispo cemetery, crei WISBUG	matory or othe	r place)	3.04 L	oc. Location - City or	PA
Depart Import eny inj		Vaugh C. S 23a. Part1. Enter the disease, or co	heene	10	125 Lik	address of Facility Q	mdA115 to	cen MD .	91133 Approximate
hysician /Medical		shock, or heart failure. List onl tmmediate Cause (Final disease or condition resulting in death)	ly one cause on each line.	deco		edio vasa			Interval Between Onset and Death
xaminer	Examiner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):					
ysicien and	cal	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):					
within 24 hours after death. To the Funerei Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	el death 3	⊒Ectopic pregr ⊒ Other <i>(speci</i> i			23d. Date of de Month	livery Day Year
been signed by the should be detached	by	Part II. Other significant conditions Hippertense	contributing to death but not re-	sulting in the u	inderlying caus	e given in Part I.			o the cause of death?
sate has bee	Completed	_ fheimato	id altheits				24a. Was an autopsy performs	prior to death?	utopsy findings available completion of cause of
r this certifica	To Be (25. Was case referred to medical examiner? 1 \sum Yes 2 \text{No}	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3□ DOA	Other	th (Check only one)	ce 6 □Other (Spe	icify)
tending regions and total the funeral	Certification:	27. Manner of Death XNatural	be	28b. Time o Injury	М	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how		
to the troughten or Attendamy Fri within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral		4 Homicide determine	building, etc. (Speci	owiedge, deati	h occurred at t	he time, date and place,	City or Town,	se(s) and manner a	s stated.
within 24 to the Fu	Medical	(Check only one) 2 Medical Example of Certifier	aminer: On the basis of examinand manner stated.	ation and/or in	vestigation, in	my opinion, death occur cense number	red at the time, date	e and place, and du	e to the cause(s)
C_{r}		30. Name and address of person who	o completed cause of death (Ite	m 23a) (Type,		32158	4	1/28/0	<u> </u>
		Jeotin Pali 31. Date filed (Month, Day, Year)	Kh, MD 821 t	J. Ew	taw St	seet, sui	te 407;	Bultimo	ee, MD 21201

DHMH 17 Rev 1/2001

Phyllis chappelle.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State	State of Maryland	d / Depa	artment of H	lealth and		21101	102107	
	Planeiai		- State Registrar AMFND TTFM 31 1. Decedent's Name (First, Middle, Last)		tillicate of t	Jeani	2. Date of Deat Month	ng. No. 🚄 🔾 🐧 🤄 Day Year	3. Time of Death	
	Physici /Medic	al .	CARTER, EACL	EARL CARTER		4b. City, Town, or	Location of Dogs	0	23 QCC	04 18 PM	
	Examin	er	4a. Facility Name (If not institution, give UNIVERSITY OF MAR		CEVIER	Baltim			Baltimor		
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. I.	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	inthplace (State or Foreign Country)	
1	Director	-	Usual Residence of Decedent	M 20F 77	Yrs.			09/12	26 Jenl	kins,Kentucky	
	iryland ihow		10a. State 10b. County	1 -	, Town or Lo					10d. Inside City Limits 1 Yes 2 No	
	the Ma	ecto	Baltimore 10e. Street and Number	1	NUITI	10f. Zip Code	nty	10	Og. Citizen of What C	A	
	3a or	Funeral Director	9109. CARUSTE	AVENUE.		212	36		USA	,	
	r death	ner	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Arr Black, Wh		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturat", or items 23a or 28a-f ahow other traumatic event, the Medical Examiner must be maillised at	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XIYes 2 ☐ No If Yes, Give Year or Dates: WW T		1 ☐ Yes 2 ☐xNo	Specify:		Specify: W	nite	
21215-0036	72 hou	eted	15. Decedent's Edu (Specify only highest grad	cation	16a Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	rking	16b. Kind of Busines	s/Industry	
121	be filed within all Hygiene. I other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Engine		0		Ravtheon		
d 2	e filed al Hygi other	Be Co	17. Father's Name (First, Middle, Last)	LYZI	ценк	<u>-1</u>		me (First, Middle, A			
Maryland	2 should be and Mental is marked of aumatic ever	Tof	Durward Carter	Original and the second	tob Maili		Elizabet		City or Town State	Tin Codel	
Mar	nd 2 sh Ith and 27 is m		19a. Informant's Name/Relationship (T) Doris M.L. Carter (Wit					imore, Mary	City or Town, State,	Zip Code)	
Je,	of Hear filtern		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. P	lace of Dispo	osition (Name of matory or other place			20c. Location - City of	or Town, State	
Baltimore,	0-10		*4 □Donation 5 □ Other (Specify,	Gan		Faith Cem.		8 2004 B	altimore,Ma	ryland	
Bai	permit. Pa Departmen Important: sny injury oncs.		21. Signature of Funeral Service Licens	Ofrance V.	Ta	2. Name and Address assam Funci	ral Home T	nc more Marsyl	and 21236		
w -	7 - 8										
	Physician	2 1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a								
1	/Medical Examiner			Due L (or as a consequ	Jence 2	ain imi	uni 2º	Fall	· K	>	
	P =	ner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):		95	حابا (ع اب	MA		
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):			n ox			
8760	ys e	cal E		d		<u> </u>	N.N.	130	Ĉ.		
9	leath certifica attending ph I for use as th	9	IF FEMALE:	00- 14			191	O EDICAL			
Box	attend after us	clan	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	☐Ectopic pregnancy ☐ Other (specify)	1 North		23d. Date of de Month	elivery Day Year	
P.O.	that the dead by the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		kO	Mich h.				
	ires tha signed I I be det	by	Part II. Other significant conditions co	entributing to death but not resu	ulting in the u	inderlying cause	in Part I.	23e. Did tob	1-/	to the cause of death? Probably 4 Unknown	
corc	w require been si	Completed						24a. Was a	24b. Were a	autopsy findings available	
Re	The lav ate has page 2	фшо						autops perform		completion of cause of	
Division of Vital Records,	Physician: this certifica al director, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or	ath (Check only on	9)		
of		\vdash	1 Security 2 Produption 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)								
ion	Attending I death. ctor: After y the funer	Certification:	1 □ Natural 5 □ Pending 2 □ Accident investigation	3/11/	Faind 100	y M 1□		subj	ect fell		
)ivis	or Attendenter de Directo	rtific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specif)	ome, farm, st	reet, factory, office		City or Town	reet and Number or F , State) VISLO Ave	Rural Route Number,	
	Hospital 4 hours a Funeral I			sician: To the best of my kno				e, and due to the ca	use(s) and manner		
	To the Hospital or Atti within 24 hours after de To the Funeral Directo completely filled in by ti	Medical	one)	iner: On the basis of examina and manner stated.	tion and/or in						
	Will To	-	29b. Signature and title of certifier	the my		29c. Licens			Out of a		
	/		30. Name and address of person who d	completed cause of death (Item	1 23a) (Type,	Print)	100106	J	inuahu 2	-), L(Y)4	
	10		31 Date filed (Menth Day Veer)	200 32. Registrar's Signa	ture 3	Eigene.	511-e	+ ta	ito.nd	31301	
	Sta		31. Date filed (Month, Day Year) 2 9	ZUU4 Zugara saigna	A.S.	SOME					

			. For	•		/ Depa	artment of H	eaith an		al Hygie	ane.		02	108	
			1 - State Registrar					120	Reg. No. 2004; 02 08						
	Physicia	an	1. Decedent's Name (First, Middle, Last) Jeanette Estie			0				January 21, 200			12:1		
	/Medic	al			170 61		4b. City, Town, or			ilual y		unty of Death	14.1) AIT	
	Examin	er	4a. Fecility Name (If not institution, give stre						Jeetn			ederic	.le		
1			Beverly Health Car 5. Social Security Number 6. Sex			et hiethelau)	Freder	ff Under 24	Hrs. 8 D	ate of Birth	FI		place (State	or Foreign	
	Funeral Director		219-36-4027 1DM	2 💢 F	e (In yrs. las 84	Yrs.	Months Days		Min. Ma	y 31,	1 919	Con	aryla	nd	
Z1Z15-UU36 d within 72 hours after death with the Maryland	pue *	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation						10d. fnside C	City Limits	
	Manyla f eho		Maryland Freder	ick	,		Frede	erick						s 2 □ No	
	with the a or 28a be notif	Funeral Director	10e. Street and Number 1085 Rocky Springs Road				10f. Zip Code 10g.					. Citizen of What Country? U.S.A.			
	eath	era					/as Decedent of Hispanic Origin? (Speci			res or No-	14.	14. Race - American Indian,			
	fler d	To Be Completed by Fun	1 Never Married 2 Married	Armed Forces?		1	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I			Rican, etc.)		Black, White,	e, etc.		
	urs a		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No II Yes, Give Year or Dates:				I□Yes 2□XNo			Sp	ecity: Wh	White			
	2 ho		15. Decedent's Educat (Specify only highest grade c	ion		16a. Deced	lent's Usual Occupa	ation	fundina	16	b. Kind	of Business/In	dustry		
7	en r		Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work done of OO NOT use retired,))	working						
	er th		Homemaker							Own Home					
iore, maryland	ild be fill lental Hy ked oth ilc event		17. Father's Name (First, Middle, Last) Harry M. Free 18. Mother's Name (First, Middle, Last) Estie Kline							, Maiden Sumame)					
	d 2 sho th and 7 is m traum	-	19a. Informant's Name/Relationship (Type, Harry Douglas Camp				g Address (Street a							21702	
	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Rem	noval from State	20b. Plac	ce of Dispo	sition (Name of Patory or other clack LINES CEII	etery	Date Jan.	23, 20	c. Locati	ion - City or To Freder	own, State	——— Maryla	
Baltimor	permit. Pa Departmer Important eny injury once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee	m. 1	1	22 V	. Name and Addres								
D	20 E 9 9		Marad C.C.	Mafer	£1000	21 1	06 East C	hurch	St.	Freder	rick.	MD 21			
	Physician		23a. Part1. Enter the disease, or complical shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	Primary	Thro	mbocy		g, such as car	rdiac or resp	oiratory arres	t.,		Approxima Interval Be Onset and	tween	
	/Medical Examiner		Tosting in dodain	Due to (or as	a conseque	nce of):									
	*	er	Sequentially list conditions, if any, leading to immediate												
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events c.												
/60,	eath certificate be executed attending physician and for use as the buriat-transit	Exa	resulting in death) Last	Due to (or as	a conseque	nce of):									
	ate be hysici	Ical	d.												
200	artifica ing pl	d by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 3Ectopic pregnancy												
ă	ath ce ttend or us									23d. Date of de Month			elivery Day Year		
j	The law requires that the death certificat te has been signed by the attending phyage 2 should be detached for use as the		1 ☐ Yes 2 ☑ No 9 ☐ Unknown	es 2 Ano 4— regnant at time of death 5— Other (specify)							indian bay				
<u>.</u>	that the de led by the a detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								contribute to ti	he cause of	death?		
g _S	w requires that been signed b should be deta									1 🗌 Yes	Yes 2 ™No 3 Probably 4 Unknown				
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ě	The lav ate has page 2	m d							autopsy prior to completion of cause			cause of			
<u>_</u>			OS Man area referred to medical	are case reterred to modical						☐ Yes 2 ि	No	1 🗆 Yes	2 PNo		
Vital	certi	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital:	۰۰ ۵۵۵	2/0.1-1	Othe			eck only one)		_			
TO L	ing Physical distribution		1 Tes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA 4 Norsing Home 5 Heside										y)		
20	oter: A y the fu	cat	2 Accident investigation M 1 Yes 2 No						Leaving (Charles of Murchas & Co. Co.						
	tal or Al s after c al Direc ed in by	Certification:	3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									s)			
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)												
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	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 9 2	32. Registra	ar's Signatui	re .	forthe !		,						

State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, La	ort)	Certificate o	f Death		g. No. 2	0040	210
П	Physician					2. Date of Deeth Month	Dey	Year	of Death
-	/Medica		Cox			January	26, 20		O AM
and the	Examine				4b. City, Town, or Lo		4c. County		
		2817 Rocks Road			Jarretts		Harf		
ı	Funeral Director	218-14-8270	Du No.	3 Yrs. If Under 1 Yes Months Day		8. Date of Birth (Month, Day,) Feb. 8,	^(ear) 1920	9. Birthplace (State Country) Maryland	or Foreign
	B .	Usuel Residence of Decedent 10a. Stete 10b. County	10c City T	own or Location				40d tasida	Cia di Interior
	anyle sho							10d. Inside	s 2XINo
	788-1	Maryland Harford	d Jar	rettsville					
		10e. Street end Number		10f. Zip Code		100		What Country?	
	ath 123	2817 Rocks Road			.084		US		
21215-0020	pamilt. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any highly or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Filineral Director	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	Hispenic Origin? (Spilban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc. White	
ò	tura itura	15. Decedent's Ed		6e. Decedent's Usual Occ	unation	16	Sh. Kind of Ru	usiness/Industry	:
15	led within 72 ho ygiene. ver than "natura rt, the Medical Completed	(Specify only highest gra	de completed)	(Give kind of work don life. DO NOT use retii	e during most of work: red)	ing		ford Coun	tv
172	with than	Elementary/Secondary (0-12)	College (1-4or 5+)		55,			f Education	
	Hygin Hygin	17. Fether's Neme (First, Middle, Last)		Secretary	18 Mother's Name	e (First, Middle, Ma			
Maryland	od offi							9)	
2	hould to	Mack Coy Mox1e 19a. Informent's Name/Relationship (1)		10. 14. 11		(nmn) C		A 31 - A 32 - A 37 1	
Ma	12 s h an r la r			19b. Mailing Address (Street					
ď	land m 2 ther	Herbert B. Cox /		2817 Rocks R			•		
Baltimore,	parmit. Pages: Department of F Important: If Ite any Injury or of phose.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		e of Disposition (Name of etery, crematory or other p				City or Town, State	
Ë	men men ment: ury	4 Donation 5 □ Other (Specify	Bel.	Air Memorial	Gardens 1	-29-04 B	el Air	, Marylan	d
a	ppart port y in	21. Signature of Funeral Service Licen	see	22 Name and Add	Funeral Ho	me. P.A.			
Ш	20 = 20	* Hule IV NY bon	askemut		oadway St.		r. Mar	vland 210	14
		23a. Part1, Enter the disease, or comp	lications that caused the leath. [Approxima	
	Physician /Medical	shock, or heart ailure. List only of the shock of heart ailure. List only of the shock of the sh	Pne nm	pn(4				interval Be Onset and	
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	eath certificata ba axecuted ettending physician end for use es tha buriel-transit clan/Medical Examir	Sequentially list conditions.	Due to (or as	e consequence of):					
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68760,	ficata ba physicie s tha bu	that initieted events resulting in death) Last	C. Due to (or as	a consequence of):					
39	ing ph	resulting in death) Last		3 12 -1020 12					
Вох	andir use		d						
B	at the death ce d by the ettend atached for us Physician/	Part II. Other significant conditions co	atributing to death but not regulting	n in the underlying cause of	iven in Part I	22h Did tohe		and have to the course	of dooth?
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<u> </u>	as that igned to be dat	Parkins	ens disease			I L Yes	2 L NO	3 Probably 4	1 Ouknown
of Vital Records,	The law requires that the death certificate be assecuted sate has been signed by the ettending physician end page 2 should be datached for use as the buriel-transit Completed by Physician/Medical Examin	Conges	ins disease	failne		24a. Was an a performe	autopsy d?	24b. Were autopsy available prior completion of of death?	rto
č	The la ata ha page ?					1 Yes	ZINU	1 [] Yes 2[T No.
tal	certificat rector, p	25. Was case referred to medical			00 Blood 6 Book		2)24140	11,165 21	7 140
>	Physician: this certific ral director,	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outantiant 20 204 0	26. Place of Death				
o	Phys	15.00		Outpatient 3 DOA	4 Li Nursing Hor	ne 5 Residence 28d. Describe how			
5	After fune	1 ☑ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	Injury We	ork?]Yes 2 □ No	.oo. Describe now	injury occurre	30	
Division	al or Attending P s aftar death. In Director: After the ad in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be	One Place of Injury At home			04 1 (04			
Ξ	or Al	4 ☐ Homicide determined	28e. Plece of Injury - At home, building, etc. (Specify)	tarm, street, factory, office) 2	City or Town, S		er or Rural Route Nui	mber,
	neur neur neur neur neur neur neur neur	29a. Certifier 1 Certifying Phy	sician: To the best of my knowled	ge, death occurred at the t	ime, date and place, a	nd due to the caus	se(s) and mar	nner as stated.	
X	To the Hospit within 24 hour To the Funer completely fill Medical	one)	ner: On the basis of examination and manner stated.	anwor investigation, in my	opinion, death occurre	o at the time, date	and place, a	no due to the cause(,5)
	¥ithir To To t	29b. Signature and title of certifier	~ . ^	29c. Licen	se number	29d.	Date/signed	(Month, Day, Year)	
		Samuel	(Queno W	4) DO	N4104)	1/24	104	
	0,	30. Name end eddress of person who co		a) (Type, Print)		-	, 0	. 1	MO
100	1	31. Dete filed (Month, Day, Year))UNSO MN) 32-Registrer's Signature	5505 Hop	kins Bayu	ientri	cle De	, Itimore	1224
	State Registrar	1511 9 0 200	6	Angell 1					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 45 AM **Physician** Jamon oloria Chew 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore Year If Under 24 Hrs. Joseph Rithre 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F Days 212-36-0150 6 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow or other treumatic event, the Medical Examiner must be notified at 1 Nes 2 No MD Director Baltmone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 or items 23a /houn To Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other treumatic avent Elementary/Secondary (0-12) College (1-4or 5+) Nursing vinte Outy 74 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Gorman (OURMEN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 2814 Avenue Williams Balt Walbrook Antony Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayurew Gremston 1/26/04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address / Facility Service License 21. Signature of Funeral Sewice, P.A Hari P-Ch 209 Tessier 212014823 23a. Part1. En er the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2(VICa /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4. ØUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2E No the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending death. 1 🗌 Yes 2 🗌 No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 9 2004

Registrar's Signature

30. Name and address of person o completed calls of death (Item 23a) (Type, Print)

Society

			1 - For State Registrar Amend Item#1		•	0-	artment of F rtificate of	lealth and M <i>Death</i>		ene g. No. 2 (006	0211
			Decedent's Name (First, Middle, I		82/4/U4 E	W			2. Date of Death		Year	3. Time of Death
	Physici /Medio		George John	Deros					JANUAR			12:27 KG
<i>)</i> -	Examir	er	4a. Facility Name (If not institution, g	nive street and num	al Cen	ter	4b. City, Town, o	r Location of Death	on	4c. County		imore
	Funeral Director		5. Social Security Number 6 219–28–0668	Sex XXM 2□F	7. Age (In yrs. la	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 9,	Year) 1930	9. Birthpl Count Gre	• •
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation				10	0d. Inside City Limits
	Maryl	tor	Maryland N/A		Ba	ltimo:	re					1)X Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 4235 Elsa Terrac	ce			10f. Zip Code 21	211	10	g. Citizen of V USA	What Count	try?
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-1 show of other than "natural", or items 23a or 28a-1 show event, the Medical Examinat must be notified at	þ	11. Marital Status 1 □ Never Married 2 ▼ Married 3 → Widowed 4 □ Divorced	Armed For			Was Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
Maryland 21215-0036	in 72 hou n "natura Vedical E	Completed	15. Decedent's (Specify only highest	Education grade completed) College (1	(Acre)	(Give	DO NOT use retire	during most of work	ing	6b. Kind of Bu		
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and	I be fiif ntal Hy ad oth	Be	17. Father's Name (First, Middle, La John S. Den					18. Mother's Name Stam		aiden Suman enjami:		
Ž	2 should be i and Mental I is markad o aumatic eve	은	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number or Rura				Code)
	ss 1 and 2 should of Health and Men itam 27 is marks r other traumatic		Stergoula G.	Deros_	Wife		5 Elsa Te	rrace Ba	ltimore.	Maryla	and 2	1211
Baltimore,	Pages 1 nent of He int: If itan iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		State C6	metery, crei	osition (Name of matory or other pla oth Cemet	ce)		oc. Location - oodlawi	-	
Balti	permit. Pages i Department of H important: If its any injury or ot once.		21. Signifure of Funeral Service Li	ensee	as)		2. Name and Addre Burgee-He 3631 Fa11	enss of Facility enss-Seitz s Road, B	Funeral	Home,	Inc.	21211
4	蜀		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cally one cause on e	aused the death	. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory arres	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a			LOPATHY	/				12 DAYS
被	/Medical Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or as a consequ AL FAI							1 YEAR
	7 =	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to ((or as a consequ	iaribe of):						
	ecuted and I-transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. UREI	or as a consequ	ence of):				 	-	12 DAYS
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.O. Box 6	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	tcome of pregnal birth 2 ☐ Fetal nant at time of de own	death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	y			te of delive	ry Day Year
S, D	uires that signed by Id be deta	by	Part II. Other significant condition CHRONIC OBSTRU	_		_		ven in Part t.	23e. Did toba	V		e cause of death?
of Vital Record	The law requires that the rate has been signed by the page 2 should be detache	Completed	MULTIPLE MYELO	MA					24a. Was an autopsy perform	ed2	prior to con death?	osy findings available npletion of cause of
ita		BeC	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only one	-	103	
of V	di S	ို	1 ☐ Yes 2 No	Hospital: 154		ER/Outpatie	IL 3 DOA		me 5 Resider 28d. Describe hov)
	ding h. After fune	tion	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	(Mont	th, Day Year)	Injury	Wo	rk?]Yes 2 □No	20d. Describe nov	v injury occurr	160	
Division	or Attendiater death. Director: A lin by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At hoing, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Stre City or Town,	eet and Numb State)	er or Flurai	Route Number,
_	Hospital 4 hours Funeral ely filled	Medical Co	29a. Certifier (Check only one) Certifying Certifying Certifying	caminer: On the ba	a best of my know asis of examinat ner stated.	wledge, deat ion and/or in	h occurred at the travestigation, in my	me, date and place, opinion, death occurr	and due to the car red at the time, da	use(s) and ma te and place,	anner as sta and due to	ated. the cause(s)
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Į	v1		Joseph	Defry	mis	SIL	D00	122409		1/2	3/09	7
	10,		30. Name and address of person w					A de la linea and town to	1/2014 24/4	7 nvi 511	m = 1	·***: 6727 X
9	Ct.	ate	JOSEPH D* ANT		Begistrar's Signal	ture		RIVE TO	ASON, MA	r(YLEPIN.	D 21	204
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			For State Registrar	State of Ma			nt of Health te of Deati	h		leg. No.	2004	02112
	Physicia	an	1. Decedent's Name (First, Middle, La Anne	G.	Dupuy				2. Date of Dea Month Jan. 1	Day	$200\overset{ ext{Year}}{4}$	3. Time of Death 6:30 PM
Mil.	/Medic Examin	al	4a. Facility Name (If not institution, given Shady Grove A	re street and number)			, Town, or Location		oan.	4c. (County of Deat	h
	Funeral Director		5. Social Security Number 6. 9 544-34-6804		(In yrs. last birthda	y) If Under Months		er 24 Hrs. Min.	8. Date of Birth 08/12/	/ T9 4	9. Birt	hplece (State or Foreign nuntry) Oregon
	Maryland -1 show	tor	Usual Residence of Decedent	omery	10c. City, Town or Gaither		· \					10d. Inside City Limits 1 XYes 2 ☐ No
	with the 3a or 28a	al Direc	10e. Street and Number 543 Tschiffely	Sq. Road	l	10f. Z	20878		,	10g. Citiz U	S.A.	ountry?
980	I within 72 hours after death with the Maryland jene. rithen *natural*, or tlams 23e or 28e-f show the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		3. Was Dec If Yes, sp	edent of Hispanic C ecify Cuban, Mexic 2 No Specif		cify Yes or No- tican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	filed within 72 hor Hygiene. other than "natura ent, 'ne Wed'cal I	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) 5 Years	(Gi	cedent's Us ve kind of w DO NOT Cher	ual Occupation ork done during muse retired)	ost of workin			d of Business tgomer lic Sc	
land 2	be filed ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Las Richard L. God		· · · · · · · · · · · · · · · · · · ·			Mary		ort		
Mary	and and		19a. Informant's Name/Relationship Juliet D. Gard	(Type, Print)	19b. Ma	iling Addre	ss <i>(Street and Num</i> mbler D	nber or Rural $ ext{rive}$.	Route Numbe Kens	r, City or	ton, State, I	Zip Code) ID 20895
	s 1 and 2 f Health i ltam 27 I		20a. Method of Disposition		20b. Place of Dis	position (N			ate	20c. Lo	cation - City or	Town, State
Baltimore,	Pages ment of I lant: If Its jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Specific Spe	ity)	Georget	own	Med. Sc	hool	01/12	/200	04 Wa	sh,DC uneral Hom
Ball	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Funeral Service Lice	Insee	To-road departments	3821	and Address of Fac 14th S	T, NV	V, Was	h,D	C 2001	.1
×	186 19		23a. Part1. Enter the disease, or con shock, or heart ailure. List ont	one cause on each lin	Θ.				respiratory ar	rest,		Approximate Interval Between Onset and Death
新	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	static E	reas	t Cance	:r				Years
L	*	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):							
,092	ite be executed sysician and he burial-transit	Ical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):							
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic 5 □ Other (2	23d. Date of de Month	livery Day Year
0	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to death be	ut not resulting in the	e underlying	cause given in Pa	rt I.		obacco u /es 2[o the cause of death? robably 4 DUnknown
Il Records,		Completed									prior to death?	utopsy findings available completion of cause of 2 No
Vital	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	int 2 ER/Outpa	tient 3 1	Othor		Check only o		S □Other (Spe	ncify)
of	ig Phy ter this neral d	on: To	27. Manner of Death	28a. Date of Inju (Month, Da		e of	28c. Injury at Work?	and the first terms	28d. Describe h			(2.0)
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification:	2 Accident investigat 3 Suicide 6 Could not determine	on be 390 Place of Ini	ury - At home, farm,	M street, fact	1 □ Yes 2		281. Location (5 City or Tou			ural Route Number,
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	dical Co	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the best aminer: On the basis o and manner sta	examination and/o	eath occurre	nd at the time, date	and place, a	and due to the o	cause(s) date and	and manner a l place, and du	s stated. e to the cause(s)
	To the	Me	29b. Signature and title of certifier	^ _	- AA A	2	9c. License numbe	er		29d. Dat	e signed (Mon	th, Day, Year)
	_		· A		MI		D35635			Jan	. 21,	2004
	,9		30. Name and address of perso In Joseph Kapian	MD 1811 P	rince Pl	pe, Print) hilip	Dr. 01	ney,	MD 20	832		
Á	St	ate	31. Date filed (Month, Day, Year)	2004 32. Registr	ar's Signature	Apar	1					

		-	For Stete Registrar		partment of Health and N ertificate of Death		ne.2004 02113
	Physicia	an	1. Decedent's Name (First, Middle, Last) Filomena	C. Digiust	ino	2. Date of Death Month Jan. 6,	Day Year 2004 4:15 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death Waldorf		4c. County of Death Charles Co.
	Funeral Director		Elderly Care 5. Social Security Number 5.77-28-8441	7. Age (In yrs. last birthda	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 7,	a Righthalace (State or Foreign
	TO .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or			10d. Inside City Limits 1-ᡚ Yes 2 ⊡ No
	ith the Ma or 28e-fi	Directo	MD Charle: 10e. Street and Number		10f, Zip Code		Citizen of What Country?
36	be filed within 72 hours after death with the Maryland nat Hyglene. ad other than "neturel", or Items 23e or 28e-f show event, the Madical Examir or must be notified at	Completed by Funeral Director	115 Jefferson 11. Marital Status 12 Never Married 2 Married		20602 3. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 hours ene. than *neturel', ne Medical Ex	mpleted b	3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. De le completed) (G	ecedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired) COUNTANT	king	b. Kind of Business/Industry deral Government
land 21	should be filed within nd Mental Hygiene. s marked other than 'umetic event, tre Ma	To Be Cor	17. Father's Name (First, Middle, Last) Joseph Digiust		Rosa	ne (First, Middle, Mai rio Tore	11i
Maryland	ages 1 and 2 should b nt of Health and Ment: I: If item 27 is marked f or other treumetic e		19a. Informant's Name/Relationship (Thelma O. Digiu		ailing Address (Street and Number or Ru n Law 2808 Ter		City or Town, State, Zip Code) .d SE $\#c461$ 20020
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □ 1 ***********************************	Removal from State	sposition (Name of crematory or other place) Med. Schhol 01/	07/2004	c. Location - City or Town, State Washington, DC
Balti	permit. Page Department of Importent: If eny injury or		21. Signature of Funeral Service Licens		3821 14th Stree	t, NW, W	
	interpretation and washing the burial-transit the b	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of) me olutructue	correspiratory arrest	a, Approximate Interval Between Onset and Death	
P.O. Box 68760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	uires that signed b d be deta	ğ	Part II. Other significant conditions co	ontributing to death but not resulting in t	ne underlying cause given in Part I,		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Records,	The law requir ate has been si age 2 should	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
on of Vital	ding Physicien: The h. Atter this certificate h funeral director, page	To Be	27. Manner of Death	Hospital: 1 Inpatient 2 EP/Outp 28a. Date of Injury (Month, Day Year) 28b. Tin	atient 3 DOA Other: 4 Nursing H	ath Check onlone Home 5 Residence 28d. Describe how	ce 6 □Other (Specify) rinjury occurred
Division	To the Hospitel or Attending within 24 hours atter death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	Mospite 24 hours Funerel etely filled	edical C	29a. Certifier Le Certifying Ph (Check only one)	ysician: To the best of my knowledge, ininer: On the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
)	To the within To the	Me	29b. Signature and title of certifier	ir. Adlow-	29c. License number D15557	290	d. Date signed (Month, Day, Year)
•	10		A. Adham M	completed cause of death (Item 23a) (T	ype. Printh d Branch Ave	e, Temp	leHills mp 20780
	St Regis	ate trar	31. Date filed (Month, Day, Year)	32. Registra Signature	To Proceed &		

			1 - State Registrar AMEND ITEM #12	State of Ma 2 PER FH G82						nd Ment		ene ,	200	4 0:	2 1 1 1
			Decedent's Name (First, Middle, Las								ate of Death				e of Death
	Physici		David Moors Daniel	S							_{lonth} nuary	Day 20.	2004		л р м
	/Medic Examin		4e. Fecility Name (If not institution, give	street and number)			4b. City,	Town, or Lo	ocation of D				ounty of D		V
			2608 Chapel Lake I	rive				brill				An	ne Ar	unde1	
	Funeral		5. Social Security Number 6. Se	7. Ag		last birthday) Yrs.	If Under Months		f Under 24 Hours	Min. (A	ate of Birth Nonth, Day, Y			Birthplece (Sta Country)	
	Director		Usual Residence of Decedent		73	115.				Ma	y 14,	193	0 Pe	nnsylv	ania
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Insid	e City Limits
	Man a-f sh iffed	tor	Maryland Anne Arun	ide1	Gam	brills								101	es 2 No
	or 28	Director	10e. Street and Number				10f. Zip	Code			100	g. Citize	n of What	Country?	
	ath wi	ral	2608 Chapel Lake D					21054				_	.S.A.		
	er des	nue	11. Marital Status	Was Decedent Armed Forces?	551-1	§71 13.	Was Dece If Yes, spe	dent of Hisp cify Cuban,	anic Origin Mexican, P	n? (Specify) Puerto Rican	res or No- , etc.)	14		merican Indiar Ihite, etc.	1,
36	rs afte	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊕Yes 2 □ N If Yes, Give Year or Dates:	19	54 -	1 🗆 Yes	¾ □ No	Specify:			s	pecify: W	hite	
21215-0036	tied within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ant, the Medical Exama er must be notified at	led l	15. Decedent's Ed	ucation	19	16a. Dece	dent's Usu	al Occupation	on		16	b. Kind	of Busine	ess/Industry	
215	hin 7:	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	i+)	(Give	kind of wo DO NOT u	rk done dur se retired)	ing most of	f working	U	.S.	Airf	orce	
2	ad wit	Con	12		,	Tra	nspor	tatio							
Maryland		Be	17. Father's Name (First, Middle, Last) John Earl Daniels						_	Name (Firs Moors	t, Middle, Ma	iden Si	итате)		
<u>Y</u> a	should be nd Mental nmarkad umatic ev	<u>L</u>				1 12 12 11									
Ma	d 2 sh th and 7 ts n traun		19a. Informant's Name/Relationship (7 Sheila Daniels/Wif								te Number. (prills				
	1 and Health Iem 27		20a. Method of Disposition			Place of Dispo	sition (Nai	me of	C DI.	Date	-			or Town, State	3
ΘĽ	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3 :			emetery, crei t Linc			ory 1	-26-20	004 Br	entv	wood.	Mary1a	and
Baltimore,	는 돈 돈 돈	1	21. Signatur of uneral Service Lizen:						-,		inco1n		-	-	
ä	Depa Impo any is	11. 7	Non 1	1 Loces		341	01 в1	adens	burg 1	Rd., I	Brentw	ood,	, MD	20722	
13			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each li	the deat	h. Do not ent	er the mod	le of dying,	such as car	rdiac or resp	piratory arres	t,			Between
	Physician	y (tmmediate Cause (Finat disease or condition	, Car	dia	call	VISE							Onset a	nd Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):				1				7	
	Lxammer	Ļ	Sequentially list conditions,	b. Usche	m	ic ca	va 10	myc	pat	hy				10	years.
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ische Due to for as	05.0	lo nt	20	Logar	t a	icon	CO.			1	10.00
<u>,</u>	execunand and all-tra	Exar	that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):	(0)	<i></i>	u	ASTU.	24		-	13	years
8760,	cate be executed physician and the burial-transit	dical		d											
Ö	tificat ng phy as th	ledi			- 0										
Вох	leath certific attending pl	an/N	23b. was decedent pregnant	23c. If yes, outcome]Ectopic p	regnancy				23	d. Date of	-	v
	ne dea the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No	4☐ Pregnant at 9☐ Unknown			Other (sp		A-1111				Month	Day	Year
P.0	The law requires that the death certific tie has been signed by the atlending p age 2 should be detached for use as		9 ☐ Unknown Part II. Other significant conditions or	entributing to death h	ut not ree	ulting in the u	ndorh/ing (auca awan	in Part I	1 2	3a Did taha	200 1160	contribute	e to the cause	of doath?
ds,	signe d be c	1 by	Mueloduspla	Stic Si	1100	VOIM	2	ause giveir	arr gitt.		1 ☐ Yes	_			□ Onknown
Ö	w requir been si should	etec	O Lieuwis Fore) ~ H	160	V () V - ()	<u>-</u>			_					
Rec	ne lav s has ge 2	Completed	RNEMMATOIO	avinvi	10					_ -	4a. Was an autopsy performe	1	prior death	autopsy findin to completion on?	of cause of
a	icien: Th certificate rector, pag		25. Was case referred to medical					2	6 Place of		Yes 28	No	1 🗆 Y	′es 2□No	
of Vital Records,	Physicien: r this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatier	nt 3 DC	Other			Residence	e 6[☐Other (S	ipecify)	100
סר	ding Phys h. After this funeral di	n: T	27. Manner of Death 1; ✓ Natural 5 ☐ Pending	28a. Date of Inju		28b. Time of trijury	f 2	28c. Injury at Work?			escribe how			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	Attending or death. ector: Afte by the fune	Certification:	2 Accident investigation				М		s 2 No						
Σ̈́	for Attendate after death Director:	rtific	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of tnji building, et	ury - At hi c. <i>(Specif</i>	ome, farm, str (y)	eet, factor	y, office			ocation (Stre lity or Town, S		Number or	Rural Route N	lumber,
	pital urs a eral D		20a Cartifier 1 Cartifuing Phy	unicina. To the best	of multipo	uuladaa daat		-4.4b - 4'	d-11 d-	1					
1	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best liner: On the basis of and manner sta	examina	ition and/or in	vestigation	, in my opin	ion, death o	occurred at	the time, date	se(s) are and pl	ace, and c	as stated. Iue to the caus	e(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29	c. License n	umber		29d	. Date :	signed (Ma	onth, Day, Yea	r)
	. > - 0		Barbara La	wso Ro	au.	MD	ī	29h	197		1.1.	3/-/	1011	2300	2004
	10		30. Name and address of person who o	completed cause of d	eath (Iten	n 23a) (Type,	Print)			. 0		INV	J	~ /	~~~
	Y	ļ, II	ocan Barbaro	11. Su	of or	510)	007	MY	UI C	atto	WILL	Cuy	Any	19.70	[45]
	Sta Registr		31. Date filed (Month, Day, Year)	AN 2°25°20	ar's Signa	Erlin.	J.	ho	1					1	

Please Type or Print in	Black Indelible Ink.	Ensure All Cop	ies Are Legible

		Please I For State Registrer	State of Marylar	nd / Dep		lealth and M	lental Hygie	_	02115
Physicia /Medic Examine	al .	Decedent's Name (First, Middle, Last) Joe Dunlap Dix Aa. Fecility Name (If not institution, give s		. 1 1	4b. City, Town, or	Location of Death	2. Date of Death Month JANNAV	Day Z () Year C. County of Dea	
Funeral Director		(1000 4 AWAV) 5. Social Security Number 219-20-6198 6. Sex	7. Age (In yrs		ISA (+	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 11,	9. Bir 1929 M	thplece (Stete or Foreign ountry) aryland
Maryland	tor	Usual Residence of Decedent	_	ty, Town or L rinces					10d. Inside City Limits 1 ☐ Yes ※XXNo
th with the 23s or 28	Funeral Director	10e. Street and Number 12883 Recycle Dri	ve		10f. Zip Code 218	853		Citizen of What Co	
72 hours after death with the Maryland 'natural', or Iteme 23s or 28s-1 show Jical Examinat must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: W	te, etc.
	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	edent's Usual Occupi e kind of work done of DO NOT use retired Mill Roll	during most of work f)	ing 16t	. Kind of Business Sparrows	
s 1 and 2 should be filed within of Heath and Mental Hygiene. item 27 le marked other then other traumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Raymond John Dix	on			18. Mother's Nam Unknown	e (First, Middle, Maid	den Sumame)	
and 2 should alth and Men 127 is marks or traumatic		19a. Informant's Name/Relationship (Ty Mary Dixon (Wife	2)	844	N. Marly	n Avenue	Baltimor		
permit. Pages 1 a Department of He Important: If iten any Injury or oth		20a. Method of Disposition 1XXBurial 2 Cremation 3 P 4 Donation 5 Other (Specify)	B B	eechwo	osition (Name of matory or other place od Cemete:	ry 1/31		. Location - City or incess Ar	Town, State
permit Depar Impor any in		21. Signate of Funeral Service Licens Classification 23a. Part1. Enter the disease, or complete	Selina	ke 6	224 Easte	Zeiler & rn Avenue	Son, Inc Baltimo	re, MD 2	224 Approximate
Prysician /Medical Examiner prize and prize l'transit prize l'transit prize l'transit prize l'entre l'	Examiner	shock, or sear failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	quence of): PATH quence of):	CESISTAN:	UNONA STAPH	AUREUS	PNEUMO	Interval Between Onset and Death
ath certificate attending phys for use as the	Physician/Medical	in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	nancy al death 3	ENAL €	DISTASE		23d. Date of de Month	livery Day Year
uires that the de signed by the a d be detached	ρχ	9 ☐ Unknown Part II. Other significant conditions con	ntributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did tobac		o the cause of death?
	Completed						24a. Was an autopsy performed Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
nysician: Th	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Anpatient 2[] ER/Outpatie	ent 3 DOA Oth	or	h (Check only one) ome 5 Residence	6 □Other (Spe	ocify)
Hospital or Attanding Physician: 14 hours after death. Funeral Director: After this certificitely filled in by the funeral director.	Certification;	27. Mannerol Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - Atl building, etc. (Spec	28b. Time Injury home, farm, s	M 1	y at k? Yes 2 □ No	28d. Describe how i 28f. Location (Stree City or Town, S	t and Number or R	ural Route Number,
To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer		sician: To the best of my kr ner: On the basis of examinand manner stated.						
To the within 2 To the complet	Mec	29b. Signature and title of certifier	N.D		29c. Licens RES			Date signed (Moni	
4	10-	30. Name and address of person who con I Z (K A I I I S K A I I I S K A I I I I S K A I I I I I I I I I I I I I I I I I I	12We 560	om 23a) (Type	ch Ravea	Blvd.	Baltin	nore M	1 28, 2004 D, 21239
Sta Registr		JAN 2 9	2004 32. Registrar's Sign	J.	Goode)				

			ricasc	State of Mary				-	-	
			For State	State of Mary	•		of Death	-	Reg. No.	02116
			Registrar 1. Decedent's Name (First, Middle, Las	st)		innouto (<i>5. 00di.</i> 7	2. Date of De		3. Time of Death
	Physicia	an	Clara Doer					Month	Day Year 1 25 2004	1:00 AM
	/Medic		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of Dea	-	4c. County of Dea	
	Examin	er	Johns Hopkins Bayun		Conter	Ball	rimore		N/A	
*	Funeral		5. Social Security Number 6. S	ex 7. Age (Ir	yrs. last birthday)	If Under 1 Y			th 9. Bi	thplace (State or Foreign ountry)
	Director		213-09-2955	□M 2\\ F 86	S Yrs.	Months	lys Hours IVIII	June 1	9, 1917 Mai	yland
	g ,		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	shov	ក	Maryland Baltimo		Edgeme					1 ☐ Yes 2 ☒ No
	28a-f	ect	10e. Street and Number			10f. Zip Co	te .		10g. Citizen of What C	ountry?
	with	by Funeral Director		D J			219		U.S.A.	,
	ns 23	era	7405 North Point	12. Was Decedent Eve	r in U.S. 13.		of Hispanic Origin? (Cuban, Mexican, Pue			
(0	r iter	ᆵ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				rto Hican, etc.)		
8	ral', o	by	3 Widowed 4 Divorced	If Yes, Give 25 Year or Dates:		1☐ Yes 2√Ω	No Specify:		Specify: Wh:	rre
5-0	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Modical Examiner riunt be molified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual O	one during most of w	orking	16b. Kind of Business	i/Industry
121	vithin ne. han	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use re	atired)		Bethlehem	Steel
2	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last,)	sort	cer	18. Mother's No	ame (First, Middle	, Maiden Surname)	
an	d be	To Be	Andrew Henry Zal					Anna Kor		
Maryland 21215-0036	should ind Men i marke umatic	-	19a. Informant's Name/Relationship (19b. Maili	ng Address (St	reet and Number or F	Rural Route Numb	er, City or Town, State,	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner rotat be notified at ODGs.		Charles Doerr-Hus	band	7405	North	Point Road	l Baltimo	re, Maryla	nd 21219
J.	of Her of Her item		20a. Method of Disposition	TD	20b. Place of Dispo cemetery, cre	osition (Name of matory or other	f place)	Date	20c. Location - City o	Town, State
Ĕ	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification)	memoval from State	Gardens o	of Fait	h 1/2	28/2004		, Maryland
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licer	nsee					pel Funera	
	207 2 2		Jessica ?	ACE .					e, Maryland	1
1			23a. Part1 Enter the disease, or com shock, or heart failure. List only	one cause on each line.		4			rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a CONGES		ART	FAILURE			1 DAY
	/Medical Examiner			Due to (or as a co	onsequence of):					
	A	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):					
	te be executed ysicien and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6						
o,	certificate be executed ding physicien and ise as the burial-transi		resulting in death) Last	Due to (or as a co	onsequence of):					
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89	ntifica ng ph as th	Med	IF FEMALE:							
Box	death ce e attendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome of p	Fetal death 3	Ectopic pregn			23d. Date of de Month	livery Day Year
0.	ne des the a	Physiclan/Medl	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	4□Pregnant at tim 9□ Unknown	e of death 5	Other (specif	y)			,
0	that the death certificate ed by the attending phy detached for use as the	Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	underlying caus	e given in Part I.	23e. Did t	tobacco use contribute	o the cause of death?
ds,	Se Di es	d by						1 🗆	Yes 2 No 3 ☐ F	robably 4 Unknown
Sor	> 0 5	lete						24a. Was	an 24b. Were a	utopsy findings available
Re	e la has	Completed						auto	psy prior to ormed? death?	completion of cause of
a	ician: Th certificate rector, pag		25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only		s 2 No
5	Physician: this certific ral director.	To Be	examiner?	Hospital:	2 ER/Outpatie	nt 3 DOA	Othor		dence 6 Other (Sp.	ecify)
10	ding Physician: n. After this certific funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time o		Injury at Work?		how injury occurred	
io	tendin Jeath. tor: Af	atlo	1 Natural 5 Pending investigatio	n		М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	al or Attending F after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not be determined		- At home, farm, st Specify)	reet, factory, of	fice	28f. Location (City or To	Street and Number or F wn, State)	lural Route Number,
۵	urs af rel D	Ce								
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical		nysician: To the best of m miner: On the basis of ex and manner stated	amination and/or ir					
	o the ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated		29c. Li	cense number		29d. Date signed (Mor	th, Day, Year)
	β ∓ ξ ⊢ λ		1	10 1		QE	5 000		Tanian 25	2004
	P		30. Name and address of person who	completed gause of deat	h (Item 23a) (Type				January 25	10001
		1			ern Auer	. 12	0.3	Mr Di	224	
			Laura Hannok	1770 Caste	ern pruer	ive, Do	utimore,	WD H	007	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's 2 9 200		ive, Do	ultimore,	IND or	807	

			ype or Print in State of Maryla	and / Depa	artment of I	Health and N	Mental Hyg	iene 2004	02117
		Registrar	·· ····	Cei	rtificate of	Deam	-	eg. No	U L I i /
Physic /Med		Decedent's Name (First, Middle, Last) JAME	S D. DOUG	HERTY_			2. Date of Deat Month Jan.	25, 2004	3. Time of Death 6:45P
Exami		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of Death	ı	4c. County of Death	
		Hart Heritage				eet	1	Harford	
Funeral Director		5. Social Security Number 6. Sex 218-14-6621	7. Age (In yi	rs. last birthday) O ^{Yrs.}	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 6/4/19	Year) 9. Birth Cou	place (State or Foreign intry) Syland
D.		Usual Residence of Decedent		O't - T 1					10d. Inside City Limits
inylar show	_	10a. State 10b. County		City, Town or Lo					1 Tyes 2 The
Ba-f	cto	MD Harfo	ora	Pyle	sville				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat missible should at	Director	10e. Street and Number		a.	10f. Zip Code	. 0	1'	Og. Citizen of What Cou	intry ?
ath w			itution R		2116			USA 14. Race - Amer	ican Indian
er deg	Funeral	11. Marital Status	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	o Rican, etc.)	Black, White	
36 safte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 2 2 14 o If Yes, Give Year or Dates:		1 ☐ Yes 3€ XNo	Specify:		Specify: wh	nite
21215-0036 ad within 72 hours aff giana. er than "natural", or than wealical Exam	pe pe	15. Decedent's Educ		16a Dece	dent's Usual Occu	nation		16b. Kind of Business/li	ndustry
7 2 6 6 6	lete	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of worked)	king		•
4 a a a a a a	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Fa	rmer			Agricultu	ire
Hygi ed 2	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M		
d be antal	To Be	Francis J. Do	ugherty			Carrie	C. Don	aven	
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	-	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address (Stree	t and Number or Ru	ral Route Number	, City or Town, State, Zi	p Code)
Ma id 2 : Iff ar 27 is	1	Lorraine Dough	erty- wif	e 211	Consti	tution	Rd.,Py1	esville,	ID 21160
Hear tem other		20a. Method of Disposition	200	. Place of Dispo	osition (Name of matory or other pla			20c. Location - City or T	
no ages ant of t: If i		XXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		-	· 1	/29/04	Pylesvill	e.MD
Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury or otherenes.		21. Signature of Funeral Service License		2	2. Name and Addr	ess of Facility	2-2-91-00	CONTRACTOR AND ADDRESS OF THE PARTY OF THE P	
Bal permi Depa Impo		1/ deen 16	Tillet	H	arkins	F.H.Inc	Delta	,PA 17314	
		23a. Pyri1. Enter the disease, or compli	cations that o used the de	eath. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate
		ck, or heart failure. List only or Immediate Cause (Final	e cause on each line.		11. 1	1	. 0		Interval Between Onset and Death
Physiciar /Medica		disease or condition resulting in death)			Heart	Failu			1 MOJ
Examine			Due to (or as a cons	sequence oi):					
V	in in	Sequentially list conditions,	Due to (or as a cons	sequence of):					
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury							
60, be executed ician and burial-transit	xal	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
	<u>a</u>		ı						
Box 687 leath certificate attending phys	Physician/Medic								
Box 68' sath certificat attending phy for use as th	Ž	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre		7e			23d. Date of deli	,
Beath atte	cia	in the past 12 months?	1□Live birth 2□F 4□Pregnant at time o		⊒Ectopic pregnand ⊒ Other (s <i>pecify</i>) _			Month	Day Year
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	by PI	Part II. Other significant conditions cor					23e. Did tol	bacco use contribute to	the cause of death?
rds quires n sign	D D	CHrone	DBStructo	TUL 1	"ulmon	any_	1 🖵 💥	2 □ No 3 □ Pro	bably 4 DUnknown
Division of Vital Records, for Attending Physician: The law requires tatler death. Director: After this certificate has been signe in by the funeral director, page 2 should be e	Completed		7) 1 yens	(24a. Was a	n 24b. Were aut	opsy findings available
I Rec	Ĕ						autops perform	med? death?	ompletion of cause of 2 No
Vital Fictorial The certificate rector, pag	Ö	25. Was case referred to medical				26. Place of Dea	ath (Check only on		18515Kd
Vil sicla s cert	0	examiner?	lospital:	2 ☐ ER/Outpatie	nt 3 DOA O	than		ence 6 Other (Spec	1851 Sted
Division of Vital Re or Attending Physician: The titler death. Director: After this certificate he in by the funeral director, page	I	27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Inju			ow injury occurred	
on on ding Ith.	후	1 Natural 5 Pending investigation	(Month, Day Year	r) Injury		ork? ∃Yes 2⊟No			
Attendi death. octor: A	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, si	reet, factory, office	9	28f. Location (Si City or Town	treet and Number or Ru	ral Route Number,
Div after Dire	Certification;	4 Homicide	building, etc. (Sp.	өслу)			City of You	ii, State)	
Division of Vita Vita No. 10 the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) (Check only one) (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, dea nination and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occu	a, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and mainer stated.			nse number		9d. Date signed (Month	
5 ± ₹ 6		10/10	m		D	3588	3	JAN. 26,	2004
_ 10		MILIA		Itom COst CT					
20		30. Name and address of person who co			rpistoi/	Bred A.	N MD.	21614	
S Regis	tate strar	31. Date filed (Month, Day, Year) JAN 2	32. Registrar's Si	ignature	Rosell	* *			

Hospitel or Attending Physician: 24 hours a per To the I the

State Registrar

DHMH 17 Rev 1/2001

Medicai

29a. Certifier

29b. Signature and title of certi

TATRICIA 31. Date filed (Month, Day, Year)

30 Name and address of person who completed

JAN 2 9 2004

SILAK 32. Registrar's Signature

of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

7:20P

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Dey, Year)

JANUARY 22,2004

Year

1. Yes 2 No

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

			For State Registrar	State o	f Maryla		artment of F		nd Menta	l Hygie	6 U	04	02120
			1. Decedent's Name (First, Middle, L	ast)					2. Date	of Death	Day	Year	3. Time of Death
	ysicia Medic		Ro	bert Geo	rge Ea	reckson	n		JA	N 27	, 2004		11:15 a M
	amin		4a. Facility Name (If not institution, git 11014 Bushwood		nber)		4b. City, Town, o				4c. County o		
					7 Age /le ves	. last birthday,		lumbia		of Ridh	How		lace (State or Foreign
Fun Dire	eral			1 □ M 2 □ F	7. Age (iii yis		Months Days		Min. (Mo.)	of Birth oth, Day, Yo	1929	Coun	vland
ס			Usual Residence of Decedent						LLL	20,	1020		
arylan show	ii ii		10a. State 10b. County			City, Town or L	ocation					1	0d. Inside City Limits
he Ma	affig	Director	Maryland Howard		Co.	lumbia	1			1.0	C 101		1 ☐ Yes 2 No
with t	2	급	10e. Street and Number	7			10f. Zip Code				. Citizen of Wh	nat Coun	rry ?
leath na 23	TO SERVICE	Funerai	11014 Bushwood V	12. Was Dece	dent Ever in	U.S. 13.	21044 Was Decedent of H	ispanic Origin	n? (Specify Ye		SA 14. Race	- Americ	an Indian,
of the contract of the contrac	i i	ᇤ	1 Never Married 2 Married	Armed Fo			If Yes, specify Cuba	an, Mexican, F	Puerto Rican, e	tc.)		White,	etc.
ours a	Exa	d by	3 ☐ Widowed 4 反 Divorced	Year or D	18 ates:		1 ☐ Yes 2 € No	Specity:			Specify:		White
72 h	857	Completed	15. Decedent's l (Specify only highest g	ducation rade completed)		(Give	dent's Usual Occup	durina most o	of working	161	b. Kind of Bus	iness/Ind	dustry
withir ene. then	e W	ф	Elementary/Secondary (0-12)	Coilege (1	-4or 5+)		<i>DO NOT</i> use <i>retired</i> Iter Progr			Fe	ederal	Gove	ernment
Hygin P	aut, II		17. Father's Name (First, Middle, Las	t)					s Name (First,				
at y failur X 1 X 1 3 - 00000 should be tiled within 72 hours after death with the Maryland nod Menial Hygiene. In not Menia 23e or 28e-f show marked other then "natural", or itema 23e or 28e-f show	ic ev	To Be	William Milton I	Eareckson	า			Lill	lian Ru	th Kea	annelly	7	
2 should be filed within and Mental Hygiene.	nume		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number	or Rural Route	Number, C	ity or Town, S	tate, Zip	Code)
and 2 ealth m 27 i	er tre		Dawn L. Eareckso	on/Daugh			.4 Bushwoo	od Way		umbia		21044	
Pages 1 nent of Hants of Hiter	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from	- 1	Place of Dispo cemetery, cre	osition (Name of matory or other plac	· 1	Date	200	c. Location - C	ity or To	wn, State
Pages tment of tent: # i	jury	1	`4 □Donation 5 □ Other (Spec	ify)			ematory]		L-28 - 04		Baltimo	re,	MD
Dattilliolo, Mal ylalla 2 12 13 0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene.	eny ir		21. Signature of Funeral Service Lice	In M	-	2	Name and Addre	Socie	ety of	MD, In	nc.	(D)	24.000
			23a. Part 1. Enter the disease, or con	regorch	LK aused the dea	ath. Do not en	299 Frede ter the mode of dyin				nore, N		21228 Approximate
Dhorat		J (shock, or heart failure. List ont	y one cause on e	ach line.	4				, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
Physic /Med	_		disease or condition resulting in death)	-	or as a conse	equence of):	ng car	cer				-	14 yrs
Exam	iner		Conventially list conditions	h									
/ 0	**	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):							
ecute	-trans	Examiner	that initiated events resulting in death) Last	C. Due to	or as a conse	equence of):						-	
be ex	the burial-transit	al E			01 43 4 001136	Auguston org.							
ficate phys	s the	edical		d			- 1						
Indecoluds, F.C. BOX 80100, The law requires that the death certificate be executed attends been signed by the attending physician and	d for use as th	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregi		75-1-5				23d. Date	of delive	ry
the atte	detached for use	sicia	in the past 12 months? 1 Yes 2 No		ant at time of		□Ectopic pregnancy □ Other (specify)	·			Monti	h	Day Year
at the diby th	etache	Phys	9 Unknown							0:1.			
res th	9	by	Part II. Other significant conditions	contributing to de	eath but not re	suiting in the i	inderlying cause giv	en in Part I.	236				e cause of death? ably 4 DUnknown
v requir been si	should	eted							-				
e law	page 2 s	Completed							248	 Was an autopsy performed 	pri	ere autor or to con ath?	osy findings available npletion of cause of
	or, pag	e Co	25. Was case referred to medical	<u> </u>				00 81		Yes 2	No 1	Yes	2 No
/sicia	directo	0 B	examiner?	Hospital:	npatient 2[☐ ER/Outpatie	nt 3 DOA Oth		ing Home 5	1	e 6 TOther	(Snecity	1
e P. G	eral	T:u	27. Manner of Death	28a. Date		28b. Time o		y at			injury occurred	1-1	,
endin sath. or: Afr	he fur	atio	1 Natural 5 Pending investigati	on	., 52, 753,	,,		Yes 2□No)				
or Atto	ı by ti	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place buildi	of Injury - At ng, etc. (Spec	home, farm, st	reet, lactory, office			ation (Stree or Town, S		or Rurai	Route Number,
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Hosy 24 ho Fune	stely (edical	29a. Certifier 1 Certifying F (Check only 2 Medical Ext	miner: On the ba	best of my kr asis of examir ner stated.	nowledge, deal nation and/or in	th occurred at the tire to the	ne, date and p pinion, death	place, and due occurred at the	to the caus time, date	e(s) and manr and place, an	ner as sta d due to	ated. the cause(s)
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	completely filled in by the funeral director,	Mec	29b. Signature and title of certifier	3110			29c. Licens	e number		29d.	Date signed (Month, L	Dey, Year)
	1		> Sow 3 Clust	on.m			05	225			Januar	v 28	. 2004
11			30. Name and address of person who	completed caus	e of death (ite	em 23a) (Type,	Print)					,	,
			SALLY B. CHE	STOW. Mi) 110	65 L	ITTLE PA	WXEN?	T PKI	4 0	DLUMB	iA.	no 21044
R	Sta egistr		31. Date filed (Month, Day, Year)	32. R	egistar's Sign	nature	Specks						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician Physic					State of Ma	aryianu			of Health and Of Death	мена пу	Reg. No. 2	nn	02121
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Second Second Number 0.5 most accomply found 15.0 colors 10.0 co	1	_xa	٠٠.	Mariner Health	Care of C	Greate	er Lau	ırel	Laurel		Princ	e Geo	rge's
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State Securior Column C	1			Lauradiata Causa /Final									Oliset and Death
Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Diabetes Mellitus Diabetes Mellitus Diabetes Mellitus Diabetes Mellitus Dehydration Dehydration	1			disease or condition	Art a	erios	clerc	otic Ca	rdiovascul	lar Disea	ase		
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Dehydration Dehyd	Э.	e dea he at hed fo	Sici	Part II. Other significant conditions con	ntributing to death bu	ıt not resulti	ing in the u	nderlying cause	e given in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
Dehydration Dehyd	<u>Ч</u>	d by t	튄	Diabetes Melli	tus					10	Yes 2□ No	3 ☐ Probe	ably 4 🔯 Unknown
State St	Ś	res the signe	2							04-14/		24h Wo	ro autonov findings
State St	0	requi	etec	Dehydration								avai	ilable prior to
27. Manner of Death 1 \(\) Natural 2 \(\) Accident 3 \(\) Suicide 4 \(\) Homicide 28a. Date of Injury 4 \(\) Homicide 28b. Time of Injury 5 \(\) Pending investigation 3 \(\) Suicide 4 \(\) Homicide 28c. Injury at Work? 1 \(\) Yes 2 \(\) No 28d. Describe how injury occurred 28d. Des	Sec.	> 10	햩						28			of de	eath?
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, 14333 Laurel Bowie Road, Suite 208, Laurel, MD 20708 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	ð	Phys rthis		1 168 22 140	I 🗆 Inpatie				+c2[Nulsing				,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, 14333 Laurel Bowie Road, Suite 208, Laurel, MD 20708 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	o	ding th. After	盲	inventiontion	(Month, Day	Year)	Injury						
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, 14333 Laurel Bowie Road, Suite 208, Laurel, MD 20708 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	ă	s effer Dire	er	4 Homicide	building, etc	. (Ѕресіту)				City or 10	wn, State)		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, 14333 Laurel Bowie Road, Suite 208, Laurel, MD 20708 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		with To t	≥	29b. Signature and title of certifier	a		1.5	29c. Lic	cense number		29d. Date signe	d (Month, D	ay, Year)
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State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		N							-0 200 -	urol Mr	20700		
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DHMH 16 Rev 6/95

		_ For	State of M	laryland					ital Hyg	giene	00100
		1 - State Registrar			Cei	rtificate d	of Deat			Reg. No. 4 U U	3. Time of Death
Physic	ian	Decedent's Name (First, Middle,							Date of Dea Month	Day Yea	r
/Medi		Rita				4b. City. Tow	1		anuar	y 24, 2004 4c. County of De	
Exami	ner	4a. Facility Name (If not institution,				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
		Carriage Hill Nu		ge (In yrs. Ia	st birthday)	If Under 1 Y	thesda ear If Unc		Date of Birth (Month, Day	Montgor 9. E	Birthplace (State or Foreign Country)
Funeral Director		136-12-3696	1□M 2⁄∏F	86	Yrs.	Months Da	ays Hour	rs Min. No	(Month, Day DV • 2 •	1917 Ne	w Jersey
	-	Usual Residence of Decedent									
yland		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2X No
e Ma	cto	New Jersey Monm	outh	Ma	nasqu	an Park					
ih th or 28	Director	10e. Street and Number				10f. Zip Co	de			10g. Citizen of What	
ath w		1600 Myrtle Aven					3736_	0:::0:0		United St	ates merican Indian,
ar deg	Funerai	11. Marital Status	12. Was Decedent	?	i. 13.	Was Decedent If Yes, specify	of Hispanic Cuban, Mexi	Origin? (Specify ican, Puerto Rica	n, etc.)	Black, W	
s affe	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🗓 If Yes, Give Year or Dates:			1□Yes 2🂢	No Spec	city:		Specify:	White
Pour Pour	edt	15. Decedent's	Education		16a. Dece	dent's Usual O	ccupation			16b. Kind of Busine	ss/Industry
n 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Give life.	kind of work di DO NOT use re	one during n etired)	nost of working			
d with	E	Elementary/Secondary (0°12)	4			Teacher	-			Educati	on
d be filed ental Hyg ked othe	BeC	17. Father's Name (First, Middle, L.	ast)				18. Me	other's Name (Fi	irst, Middle,	Meiden Sumame)	
uld by Wents Wents wirked	10	Theodore Zwisohn						Esther E			
Mar)		19a. Informant's Name/Relationship				70				or, City or Town, State	e, Zip Code)
ire, Marylating ZIZIO-000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		Randy Elkins/Son		ook Di		and the second second		ive; Mcl		VA 22101 20c. Location - City	or Town State
DTG Dges 1 To the		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Removal from State	θ		osition (Name of matory or other		1			
Pag tment tant:		'4 □Donation 5 □ Other (Spe	ecify)	Loud				y 1/28/2		Baltimo	
DallIMOTE, INITION Per INITION Pages 1 and 2 Department of Health 8 Important: If item 27 It any injury or other transmen.		21. Sign were t Funeral Service Li	2. Dim	V.	S 1	imple 1 040 Roc	ribut kvill	ë Funera e Pike;	al and Rockv	l Crematio ville, MD	n Center 20852
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause	ed the death.							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	•	ratory	Fail	ure					Onset and Death
/Medica		resulting in death)		is a consequ							
Examine		Sequentially list conditions				ive Pul	Lmonar	y Diseas	se		
D #	lie.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		is a consequ							
ecute and trans	Examiner	that initiated events resulting in death) Last		tensiv saconsegu		rt Dise	ease				
BOX 58/6U, eath certificate be executed attending physician and for use as the burial-transit	cal E		500 (0 (0)	.5 & 00.1004	51100 01):						
587 ifficate g physi as the t			d								
Hecords, P.O. Box 68 The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date of	delivery
Box leath cer attendin	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of de		∐Ectopic pregr □ Oth <i>e</i> r (<i>speci</i> i				Month	Day Year
at the de by the	hysi	9 Unknown	9□ Unknown								
IS, T	Y P	Part II. Other significant condition	ns contributing to death	but not resu	liting in the I	underlying caus	se given in P	art I.			e to the cause of death?
Cords w require been sig									1 🗆 \	Yes 2□No 3□	Probably 4 Nunknown
VITAL HECOTGS, iician: The law requires t certificate has been signe rector, page 2 should be	Completed								24a. Was	an 24b. Were	autopsy findings available to completion of cause of
He The lav Ite has	E								perfo 1 ∐ Yes	rmed? death	1?
	Be	25. Was case referred to medical examiner?						Place of Death C			
Of V Physic this ce al direc	10	1 ☐ Yes 2 💢 No				ent 3 DOA				dence 6 Other (S	Specify)
On O		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Day Yeer)	28b. Time of Injury		Injury at Work? 1 ☐ Yes		J. Describe r	now injury occurred	
ISIO ktendi death. ctor: A	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	Injury At ho	ma form o	M			Location (5	Street and Number o	Rural Route Number,
Division of tor Attending Phy after death. Director: After this in by the funeral d	Certification:	4 Homicide determi	ned 288. Place of building,	etc. (Specify	/)	treet, factory, o	HICE	201	City or Tov		
Division of Vita Vita No. 10 the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			g Physician: To the be	st of my know	wledge, dea	ith occurred at t	the time, dat	te and place, and	d due to the	cause(s) and manne	r as stated.
e Hos 24 h e Fur letely	edical	(Check only 2 Medical E	xaminer: On the basis and manner	of examinat	ion and/or i	nvestigation, in	my opinion,	death occurred	at the time,	date and place, and	due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier		າ		29c. L	icense numb	ber		29d. Date signed (M	onth, Dey, Year)
		> Jum	ws V.	1'usen	4	D47	7330			January 2	7, 2004
1	8	30. Name and address of person	who completed cause o								
/		Thomas V. Josep				n Drive	e; Sui	te 207;	Rocky	ville, MD	20852
	tate	31. Date filed (Month, Day, Year)	32. Regi	smar's Signa		A					
Regis	straf	י זותט	O COUT PA	Markey 1	5.	Smark	1				

DHMH 17 Rev 1/2001

ORIGINAL

		1. Decedent's Name (First, Middle, Last)	State of Maryla Ob per fh G				2. Dat	e of Death			ne of Death
Physici /Medi		Phillip Pa	aul Errico				Ja	nuary		04 9:1	5 A M
Examir		4a. Facility Name (If not institution, give s			4b. City, Town	, or Location of De	əath		4c. County of I		
		Doctor's Communit			Lanhai	m			Prince	George	e's
Funeral Director		5. Social Security Number 579–14–9749 Usual Residence of Decedent	M 2□F 7. Age (In y	rs. last birthda Yrs.	y) If Under 1 Yea Months Day		lin. 8. Dat (Mo Feb	e of Birth inth, Day, Y 27,	^(ear) 1921	Birthplace (Sta Country) Washing	ate or Foreign ton, D
Department of Health and Mental Ptyglene. Importent: if item 27 is marked other than "neturel", or items 23e or 28a-f show styr injury or other traumatic event, Ite Modical Examir er must be notified at 20108.	Director	10a. State 10b. County Maryland Anne Aru: 10e. Street and Number		City, Town or	Location napolis 10f. Zip Code	9		10g	g. Citizen of Wha	1 🗆 '	de City Limits Yes 2∑ No
23a o	aiD	2681 Cunningham H	ole Road		2	1401			USA		
Examiner or	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:1942		I. Was Decedent o If Yes, specify Cu 1 ☐ Yes 2 X N		(Specify Ye lerto Rican,	s or No- etc.)		American Indian White, etc. White	n,
an "netu Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dec (Giv life	edent's Usual Occ re kind of work dor DO NOT use reti	cupation ne during most of ired)	working	16	b. Kind of Busin	ess/Industry	
t te	Con	8th		Pain	ter/ Car	penter			Federal	Govern	ment
atic event	To Be (17. Father's Name (First, Middle, Last) Pasquale Errice	D				Name (First, esina		iden Sumame) .to		
e de		19a. Informant's Name/Relationship (Typ		19b. Ma	iling Address (Stre	et and Number or	Rural Route	Number, C	City or Town, Sta	te, Zip Code)	
her ti		P. Michael Errico/		702	Petersbi	urg Road	, Davi				
- i		20a. Method of Disposition ↑ WBurial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, ci	ematory or other p	olace) 1/	27/04		c. Location - Cit		е
jury		`4 □Donation 5 □ Other (Specify)	<u>}</u>		11 Cemete		27-04		uitland	•	
any ir		21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or compli			22. Name and Add	omons Is	land R	d. Ed	lgewater		
Sician		shock, or heart failure. List only on	e cause on each line.		and thousand of a	lyling, such as care	alac or respir	atory arrest	ι,	Approxi	Datwoon
niner	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	ie Fa		ilac (i Taspii	atory arresi		Interval	Between and Death
anding physician and use as the burial-transit	cai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Clisease of highly that initiated events resulting in death) Last	Due to (or as a cons	sequence of): sequence of): sequence of):		eline ncy	ilac (i Tespii	atory arrest	23d. Date o	Interval Onset a	Between and Death
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itter in scerificate has been signed by the attending physician and underal director, page 2 should be detached for use as the burial-transit of	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease of injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions conditions are referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation Could not be determined	Due to (or as a constitution of present at time of present at time of Unknown tributing to death but not 28a. Date of Injury (Month, Day Year 28b. Place of Injury - A building, etc. (Sp. incian: To the best of my ler: On the basis of examples.)	sequence of): se	ent 3 DOA of 28c. In W 1 street, factory, office ath occurred at the investigation, in my 29c. Lice	26. Place of I Other: 4 Nursin Jury at Nork? Yes 2 No	23 24 1 Coeath (Checo g Home 5 28d. De 28f. Loc City ace, and due	e. Did tobad 1 Yes a. Was an autopsy performed a very	23d. Date of Month 24b. Wer prior 24b. Wer prior 27	Interval Onset a L Co extended on the cause of delivery Day te to the cause of Probably 4 e autopsy finding to completion to completion the completion of Rural Route In the cause of the	Year Year of death? Unknown ngs available of cause of
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	State of Maryland / Departs	ment of H	ealth and	Mental E	-lvaiene	

FRI	EDERICK	Α.	FOX For State Registrar	State of	Maryland / D	epartme <i>Certifica</i>			Mental Hy	giene Reg. No.	Z 111113	02124
			Decedent's Name (First, Middle	e, Last)					2. Date of De		y Year	3. Time of Death
	Physicia /Medic		FREDERICK A.	FOX					JAN.	27,	2004 Year	0651 A M
	Examin		4a. Facility Name (If not institution	, give street and num				Location of Dea	ith		County of Death	
			ROUTE# 40 NORT				ATONSV	/ILLE If Under 24 Hr	S O Date of B		ALTIMORE	place (State or Foreign
	Funeral		5. Social Security Number 216-54-2104	6. Sex 1∑M 2□F	7. Age (In yrs. last birti 53	(rs. Month		Hours Mir		ay, Year)	Cou	TLAND
	Director	}	Usual Residence of Decedent						1-22-1	.901	PIAKI	LAND
	land ow		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Man,	to	MD. N/A	1	BALTIM	ORE						1X Yes 2 No
	h the	irec	10e. Street and Number			10f.	Zip Code			10g. Cit	izen of What Cou	ntry?
	th will	Funeral Director	939 ST. AGNES				21207				JSA	1 11 1
	r dea	nei	11. Marital Status	Armed Fo		13. Was De If Yes, s	cedent of Hi pecify Cuba	ispanic Origin? (n, Mexican, Pue	Specify Yes or N erto Rican, etc.)	0-	 14. Race - Ameri Black, White, 	
36	or it	by Fi	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	IT YAS GIV	2 No	1 ☐ Yes	2 X №	Specify:			Specify: BLA	ACK
215-0036	72 hours after death with the Maryland natural', or Itema 23a or 28a-f show dical Exacultar must be redilled at	edt		t's Education		Decedent's U	sual Occupa	ation		16b. K	ind of Business/Ir	ndustry
15	n na	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1	-40(5+)	(Give kind of life. DO NO	work done d Luse retired	turing most of w	rorking			
212	d within giene.	Com	-12-	-1-		JOURN	EYMAN				MACHIN	IST
pu	be file ital Hyg id othe event,	3e C	17. Father's Name (First, Middle,	Last)					ame (First, Middle		Sumame)	
<u> </u>	Menti Menti arked	To Be	ALOYSIUS FOX						ABETH WH			
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Me.	a l	19a. Informant's Name/Relations								or Town, State, Zij ZLAND 212	
	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hydene. If item 27 is marked other than "natural", or itema 23a or 28a-1 show or other traumatic event, the Medical Exaction must be notified at		SHIRLEY FOX (V	NIFE)	20b. Place of	Disposition (/	Name of		5-2004		ocation - City or T	
Baltimore,	iges if ite		1/E Burial 2 2 Cremation	3 Removal from	State cemeter	y, crematory`d	or other plac		o − 2004			s, MARYLAND
Iţi	it. Partmer		° 4 □ Donation 5 € Other (S 21. Signature Funeral Services	<i>Specify)</i> Treensee T∩NAT	GAKKIS HIR G MAH'	N F22. Name	ESI VI	ETERANS	ITLLTPS 1			
Ba	permit. Pages Department of Important: If I any injury or o		buntto	1 -11 -	me)	1721-	27 N.	MONROE	ST. BAL	ГІМОЕ	RE, MARY	LAND 21217
			23a. Part V. Enter the disease, o shock or heart failure. List	r complications that of	caused the death. Do r	not enter the n	node of dyin	g, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	torny one cause on e	Multiple (or as a consequence	e Iv	vjuvie	1				Onset and Death
	/Medical		resulting in death)	Due to	(or as a consequence	of):)					
12	Examiner	No.	Sequentially list conditions,	b. — Due to	(or as a consequence	of):						
10	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consequence	01).						
	be executed sicien and burial-transit	хап	that initiated events resulting in death) Last	c	(or as a consequence	of):						
8760,	Attanding Physician: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit	lical E		l d								
9	tificate ig phys as the	edic										
Box	eath certific attending pl	M/m	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy birth 2 Fetal death	3∏Ectopi	c pregnancy	,			23d. Date of delive	very Day Year
	death	Physician/Med	in the past 12 months? 1 Yes 2 No		nant at time of death	5 Other					Month	Day
P.0	that the de ed by the a detached i	Phy	9 Unknown			n dhan ann al antair		on in Part I	23e Did	tobacco	use contribute to	the cause of death?
	res that signed be det	by	Part II. Other significant condit	ions contributing to d	eath but not resulting i	i tile dildeliyii	ig cause giv	on ner ares.			. #	bably 4 Unknown
oro	w require been si should b	Completed							24a. Wa		7	opsy findings available
Sec.	e law has b	mpi							_ aut	opsy formed?	prior to co	ompletion of cause of
a	i ician : Th certificate rector, pag							00 Di (E	104 Yes	2 🗆 No	1 X Yes	2 No
Division of Vital Records,	siciar certif recto	Be c	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hoopital:	Inpatient 2 ER/Ou	utpatient 3	DOA Oth		eath (Check only		€XXOther (Spec	ity) AT SCENE
of	Phys r this srat di	.T	27. Manner of Death		of Injury 28b.	Time of	28c. Injur Wor		28d. Describe			moter
o	ding th. : Afte	atlor	1 □Natural 5 □ Pend 2 🛭 Accident invest	ing (Mon tigation 4-27	-64 6=	njury 45 Å M		Yes 2 No	Pedest	reian	Struck 6	y a vehicle
Visi	Attar r dea actor by the	ifica	3 Suicide 6 Could	mined 200. Flaci	e of Injury - At home, fa ling, etc. (Specify)	ırm, street, fac	ctory, office		28f. Location City or T	(Street a	nd Number or Ru	ra Route Number, Vs St Agnes
Ö	s afte	Certification;	4 D Homode	1	ing, otor (opcony)	Rea	d		Lane		1+ more	
X	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical ((Check only 2 Medica	Examiner: On the b	e best of my knowledge basis of examination ar	e, death occur nd/or investiga	red at the til	me, date and pla opinion, death or	ace, and due to the	e cause(s e, date an	s) and manner as id place, and due	stated. to the cause(s)
7	To the H within 24 To the F complete	Medi	one)	and mar	ner stated		29c. Licens				ate signed (Month	
	To To Con	1	29b. Signature and title of certific	er WiD				.M.E			-	2004
	'n	X	my			Chan Date				J.		
	9	1	30. Name and address of perso	n who completed cau			treet	, Balti	more, Ma	ryla	nd 21201	
	S	ate	31. Date filed (Month, Day, Yea	r) 32.1	Registra Signature	3.4	P .0	~		-		
	Regist		12	N 2 9 2004	Mislus	S. P.	porte	,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Oate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 7:20 FM Lillian Elizabeth Finnegan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 2□ F 217 01 0643 93 June 21 1910 Baltimore,MD Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County ral, or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 4109 Pinedale Drive 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo 21215-0036 If Yes, Give Year or Dates: Ď 3 ☐ Widowed 4 ☐ Divorced White natural in Medical Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Robin Sales N/A Bookeeper. 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Health and Mental Is marked Margaret Maher James McClerking 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 4109 Pinedale Drive Baltimore, Maryland 21236 Georgia L. Crawford (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc January 29 2004 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Manyland 21236 21. Sign sure of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a ATRIAL FIBRILLATION WITH RAPID VENTRICULAR RATE **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year for 4□Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed2 death? 2 No certificate or Attending Physician: after death.

Director: After this certific.
In by the funeral director. 26. Place of Death (Check on one 25. Was case referred to medical examiner? Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient Certification: To 28b. Time of injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitat o within 24 hours aft To the Funeral Di completely filled in 10% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mehta M.O DØØ41410 Jonnary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 TOWSON. 7601 OSLER DRIVE. JOGINDER P. M. D 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

		1	State of Maryland / Department of Health and Mer State of RegistreAMEND ITEM #10f PER FH G827 1/29/04 Gentificate of Death	ntal Hygien Reg. No	711111	02126
		6	1. Decedent's Name (First, Middle, Last) 2.	Date of Death	3	. Time of Death
	Physicia /Medic			.N 26	2004 /	: 48 A M
	Examin	_	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	C. County of Death	
€.	- w		HOSPICE OF BALTIMORE-GILCHRIST CENTER TOWSON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	9 Birtholaci	e (State or Foreign
	Funeral Director		216-18-3570 1X M 2 F 78 Yrs. Months Days Hours Min. AP	Kill I'4 Year	925 MD MD MD M	
	pu »		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d.	Inside City Limits
	Aaryla I show	ō	MD BALTIMORE BALTIMORE			1 ☐ Yes 2 🛣 No
	r 28a-	Director	10e. Street and Number 10f. Zip Code		itizen of What Country	?
	th with		8219 SCOTTS LEVEL ROAD 21209 21208	USA		
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturel", or Itama 23a or 28e-f show is marked other than "naturel", or Itama 12a or 28e-f show raumatic event. I'm Medical Evanitet must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricci II Yes, Sive Year or Dates:	/ Yes or No- an, etc.)	14. Race - American Black, White, etc WHI Specify:	TE
Baltimore, Maryland 21215-0036	hin 72 ho e. en "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		Kind of Business/Indus	try
21	led will lygien her th	Con	5 + CHIROPRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (F		ROPRACTIC	
and	d be fi	o Be	JOSEPH FALK ZELDA	RESNEKOV		
ary.	should nd Me s mark umati	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R	oute Number, City	or Town, State, Zip Co	ode)
ž	and 2 salth a n 27 is		MRS. JEANETTE E.FALK/WIFE 8219 SCOTTS LEVEL ROAD BA		MD. ZIZU8 Location - City or Town	State
more	Peges 1 ent of He nt: If iten ry or oth		20a. Memod of Disposition 1 M Burial 2 Cremation 3 Removal from State GREATER, BALTIMORE 1/28/20	DO4 BAL	TIMORE,MD.	
Balti	permit. Peges 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic ex <u>once.</u>		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL 8900 REISTERSTOWN ROA			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.		A	pproximate terval Between
	Physician		Immediate Cause (Final disease or condition a. Metastatic proof the Condition a.		•	nset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		,	
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50°	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):			
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of Vital Records, P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ Unknown		23d. Date of delivery Month Da	ay Year
20.	res that the signed by be detact	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
rds	w requires been sign should be	ed b	longesting heart failure	1 🗆 Yes	2 No 3 Probab	ly 4 □Unknown
l Reco	The law requisite has been page 2 should	Complet		24a. Was an autopsy performed? 1 ☐ Yes 2,201	prior to comp death?	y findings available letion of cause of
∠ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home		e korbar (o-ari	HOSPICE.
≥5	Phys or this aral dir): To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c.	d. Describe how in		110-1100
S io	Attending for death. actor: After by the funer	atlor	2 Accident investigation M 1 Yes 2 No			
alt med	in Dirt	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street City or Town, Sta	and Number or Rural F ate)	Route Number,
12	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause at the time, date a	(s) and manner as statend place, and due to the	ed. ne cause(s)
~	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number		Date signed (Month, Da	•
	17		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		nuary 26 THORE M	- 1
_	/5			st Bult	THORE M	D 21204
- 1	St Regis	ate trar	31. Date filed (Month, Day, Year) JAN 2 9 2004 32. Registrar's Signature			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure Ail Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month Year 2:40 A.M Glover 2004 Henrietta Jean Janvan 4b. City, Town, or Location of Death Facility Name (If that institution, give street and number) 4c. County of Death TEN BU If Under 24 Hrs. 7. Age (In yrs. last birthday) Hrundel HRUNder If Under 1 Year 8. Date of Birth (Month, Day, Year) MAY 28, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Days 1 M 2 TXF Yrs. 79 Pennsylvania 181-14-8933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1831 Norfolk Road 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Papke Loretta Nedlev 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, MD William F. Glover/Son 1831 Norfolk Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 1-29-04 Baltimore, MD 21. Signature of Daneral Service Licensee 22. Name and Address of Facility Cremation Society of 299 Frederick Road MD. Inc. Baltimore, Gregorchik Edward A 21228 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cam Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or es a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 🗆 Yes 2X No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 3 DOA 2 ER/Outpatient 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, use Completed by page 2 Be Certification: To this within 24 hours after death. To the Funeral Director: A Director: A

Physician

Examiner

Funeral

Director

Show

na 23a or 28a-f sho must be notified at

5

Funeral Director

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Completed

Be

Peges 1 and 2 should be filed within 72 hours aftar death with the Marylend nent of Haalth and Mental Hygiene.

ENCIETTA

Baltimore,

I Hygiene.

Department If Important: If any Injury or

Physician

/Medical

/Medical

Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 No

6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as steted.

— Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) (Check only and manner stated

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

8 2004

M 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PKETU 301 Hospita 31. Date liled (Month, Day, Year) 32. Registrer's Si

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State Registrar

			For State Registrar		epartment of Health and I Certificate of Death	Mental Hygier Reg. I	7004	02128
	Physicia		1. Decedent's Name (First, Middle, La	SI) GRAF		2. Date of Death Month JANUARY	Day Year 25, 2004	3. Time of Death
	/Medic Examin		4e. Fecility Name (If not institution, gir	e street and number) Medical Center	4b. City, Town, or Location of Death		4c. County of Death	timore
	Funeral Director			Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	ar) 24 9. Birthp	plece (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	w 0		Od. Inside City Limits
	e Maryla	ctor	mo N.	A	Battimore			1 Yes 2 □ No
	3a or 26	i Dire	10e. Street and Number	ne Neive	21208	10g.	Citizen of What Cour	ntry?
	ter deetl Items 2 Inet mu	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	ean Indian, etc.
2-0036	hours af tural', or al Exam	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify: Decedent's Usual Occupation	16h	Specify: BIF	ACK duetry
21215-	filed within 72 hours after deeth with the Maryland Hygiene. wher than "natural", or Items 23s or 28s-f show wit, I'm Modical Evandrat must be notified at	Completed	(Specify only highest gi	College (1-4or 5+)	(Give kind of work done during most of worlife. DO NOT use retired)	king	Donne	l.o
	2 should be filed within 72 hours after deeth with the Marylar and Mental Hyglene. Is marked other than "natural", or items 23e or 28e-f show aumatic event, If a Medical Examinar mast be notified at	Be Co	17. Father's Name (First, Middle, Las	2 4 4 5	18. Mother's Nar	ne (First, Middle, Maid	Fon Sumame)	7C
Maryland	should be and Mental Is marked o	2	19a, Informant's Name/Relationship	ICCTWINC Type, Print) 196.	Mailing Address (Street and Number or Ru	I E K . F iral Route Number, Cit	-CMI (+C y or Town, State, Zig	Code)
	1 and Health em 27 ther tr		AMREW GRA 20a, Method of Disposition	ce (Husbard) 72	200 Charkstone Disposition (Name of	DRIVE, 1	Baltmer Location - City or To	e MD212X
imore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or other once.		1 Surial 2 Cremation 3 Donation 5 Other (Spec	Removal from State	Jawn 01-3	31-04 B	altimos	e, MD
Balti	permit. Depart Import any inj		21. Signature of Funeral Service Lice	nsee In	22. Name and Address of Facility (C	Piko Batt	treens Fo impre Mi	neral Ric.
€	京 数*		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	7	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. SEFSIS Due to (or as a consequence of	of):			6 DAYS
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120	executed n and al-transi	Examiner	that initiated events resulting in death) Last	c	rf):			
68760,	icate be executed physician and s the burial-transit	dicail		d				
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death	3 □Ectopic pregnancy		23d. Date of deliver	ery Day Year
P.O. Box	that the dea ed by the at detached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (specify)		World	Day 10a1
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Records,	law requir nas been si s 2 should	Completed	THROMBOCYTOPENIA			24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
ital H	ysician: The lavis certificate has director, page 2	Be Cor	25. Was case referred to medical		26. Place of Dea	performed 1 Yes 2	death? No 1 ☐ Yes	2 No
Division of Vital	Attending Physician: r death. ector: After this certifics by the funeral director. I	မ	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Out 28a. Date of Injury 28b. T	ime of 28c. Injury at	ome 5 Residence		y)
ision	ttending I death. tor: After the funer	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	on On One Olege of Injury At home for	M 1 Yes 2 No	28f Location (Street	and Number or Rura	al Poute Number
<u>></u>	i Dir	Certif	4 Homicide determine	building, etc. (Specify)		City or Town, St.	ate)	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical	29a. Certifier Certifying F (Check only one)	hysician: To the best of my knowledge, miner: On the basis of examination and and manner stated.	, death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner as st and place, and due to	tated. the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Mella mo	29c. License number	\	Date signed (Month,	Day, Year)
	1			completed cause of death (Item 23a) (201	~ ()
70,	Sta		JOGINDER F ME 31. Date filed (Month, Day, Year)	HTA, M. D. 7601 32. Registrar's Signature 2 9 2001	M. Snaulis	SON. MARY	YLAND 21	204
old	Registi	ar -	LMI	NO OF LOUP BULLINGS	Service Marie Contract of the			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Henry W. Garvin, Jr. 01 2004 3:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2914 Smithson Drive Harford Forest Hill If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1**⊠** M 2□ F Yrs. 196-16-7819 11/27/1921 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2914 Smithson Drive U.S.A.

14. Race - American Indian,
Black, White, etc. 21050 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Amed Folces:

1 GYes 2 No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Mechanical Engineer 4 Armco Steel Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry W. Garvin, Sr. Helen Burgee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine M. Garvin (wife) 2914 Smithson Drive - Forest Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 01/24/2004 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. E, S, Xassalw 11750 Belair Road - Kingsville, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CANCER Immediate Cause (Final ROSTATE disease or condition resulting in death) Due to (or as a consequence of) BONE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 12 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit attending physicien Division of Vital Records, P.O. Box 68760 ed by the a ate has been signed page 2 should be det Be Completed by director. ٩ ctor: After thi Medical Certification; within 24 hours after deatl To the Funeral Director: mpletely filled in by

Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at

and Mental Hygiene.

nt of Health :: If item 27 i

permit. Page Department of importent: If eny injury or once.

Physician

/Medical

Examiner

8

Funeral Director

Completed by

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 Unknown
Part II. Other significant con-

5. Was case referred to medical	
examiner?	Hospital:
1 ☐ Yes 2 🗗 No	

27. Manner of Death 1 Natural 2 Accident

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and little of contrier

29c. License number

29d. Date signed (Month, Day, Year) ANUARY 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4-NORTH AHMOOD H.

MARYLAND 21014 AVENUE SUITE

Registrar

32. Registrar Signature 31. Date filed (Month, Day, Year) 2004



		-	For State			d / Depa	rtment of	Health and I	-		000	0010	
			Registrar			Cer	tificate o	t Death	-1	leg. No.	2001	The loss of the	
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	edica	1	Evelyn May Griffi						Januari	1 22,	2004	5:45 AM	
Exa	mine	r	4e. Fecility Name (If not institution, give		. 4			, or Location of Death	1	4c. Co	ounty of Death	1	
		4	Calvert Manor Heat 5. Social Security Number 6. Se			(st birthday)	Rising If Under 1 Year		R Date of Right		Cecil	unless (State or Foreign	
Fune Direct				M 200 F 1. Age	85	Yrs.	Months Day		8. Date of Birth (Month, Day NOV. 9,	Year)	Cou	pplace (State or Foreign intry) .YLand	'
ilia	101	-	Usual Residence of Decedent		-				1100. 7,	1710	Mari	yeunu	
yland		Ī	10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits	
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th wi		Funeral Director	7 Meadow Valley I	rive			2191	1		u.	SA		
r dea		ner	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13. V	Vas Decedent of Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	. Race - Amer Black, White		
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be filed within 72 hours after death with the Maryland lat Hygiene. all Hygiene. outher than "natural", or items 23a or 28a-1 show worth the Medical Engineer.		g D	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:		162 Doord	antia Haual Oca	upation		16h Kind	of Business/I	ite	
n 72		ete	(Specify only highest grad	le completed)		(Give I	kind of work dor OO NOT use reti	upation ne during most of wor red)	tking	TOD. KING	Of Dusiness/i	ildustry	
with iene.		Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5-	-)		l Secre			Hia	h Schoo	ું ગ્રે	
Hyg other		BeC	17. Father's Name (First, Middle, Last)						ne (First, Middle,				
id be lental		8 O	Hazlett Benjamin					Lillie	Chamber	S			
Lai y lail a 6 16 2 2 Should be filed within and Mental Hygiene. Is marked other than aumatic event.			19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailin	g Address (Stre	et and Number or Ru	ral Route Numbe	r, City or T	own, State, Z	ip Code)	-
ite; INIAI yilalika x 1.X 1.2-0000 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 21 is marked other than "natural", or items 23a or 28a-1 show other fraumatic event. It is Multical East set must be recited and			Herman C. Reynold	ls/Son		7 Mea	dow Val	ley Drive,	Rising	Sun,	MD 21	911	
of Hear			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Demoval from State	20b. Pla	ace of Dispos metery, crem	sition (Name of natory or other p	n/ace)	Date	20c. Loca	tion - City or 1	Town, Stete	
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parmit. Pages 1 and 2 Department of Health a Important: If item 27 is	ouce.		21. Signature of Funeral Service Licens	Pe A	3	R 22	Name and Add	fress of Facility หลับเมอหลุ่ม	Home 1	Σ.Δ			
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the att		SICI	in the past 12 months?	4☐Pregnant at t			Other (specify)				Month	Day Year	
at the day to		by Physician/Medi	9 Unknown			Min de la marca		2	OZ- Dida			the cause of death?	
The Colds, F.C. BOX 600. The law requires that the death certificate ate has been signed by the attending physica 2 should be detached for use as the			Part II. Other significant conditions co	intributing to death bu	t not resu	iling in the ur	idenying caus	yen in Part i.		es 2 🗆			,
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ospit hour uners			29a. Certifier (Check only 2 Medical Exam	sician: To the best of	f my knov	vledge, death	occurred at the	time, date and place	, and due to the d	ause(s) ar	nd manner as	stated.	_
To the Hospital or Attending Physician: The law within 24 hours after death. To the Fornerial Director: After this certificate has accordingly in the this demand infection and the things of the physician in the trivial director page.	900	ledical	one)	and manner sta	ted.	on and/or inv							
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6	70		30. Name and address of person who o	completed cause of de	ath (ftem	23a) (Type.)	Printy 1/6	Sel No 63	MI	//	A D	1078	
*	C		31. Date filed (Month, Day, Year)	32. Registra	アシング r's Bignat	ure	16 /20	in The Co	VICT	14	n for	10	
Rec	Stat sistra		IANI C	e enna	Hanas	. B	boss		(

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 12:45P M Samuel Robert Golway 01 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Prince Georges Lanham If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2□F 579-46-7481 Director 67 7/11/1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location worde or items 23a or 28a-f ehov to be must be notified at 1 ☐ Yes 2 ☐ No Bowie Directo Maryland Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 USA 12323 Whitehall Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or ite aury or other traumatic event, I'm Mudical Essus, as ury or other traumatic event, I'm Mudical Essus, as ury or other traumatic event, I'm Mudical Essus, as 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Wholesale 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harrison C. Golway Mary E. Beard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel R. Golway Jr./Son 801 Marie Lane Owings, Maryland 20736 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Pag Department Important: I any njury o Lincoln Cemetery 1-21-04 Brentwood, MD 21. Signature property of the particle Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD2103 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician Coldin allhy resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit ASDICATIO Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. P certificate has been signed by the a rector, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 100 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dabere autopsy performed 1 Yes 2 No of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2€ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pendina s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and little of 29c. License number 29d. Date signed (Month, Day, Year) 3 fame and a dress of x rso who completed cause of death (Item 23a) (Type, Print), BOWIE MD 20 A312 milchille 4000 Tavakuli Nacley 32. Registras Signature 31. Date filed (Month, Day, Year) State Registrar

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		•	For State Registrar	State of Ma	-	Certificate of			Reg. No.200	+ 02/32
	Physicia	_	1. Decedent's Name (First, Middle, Las James Donald Guy					2. Date of De Month	Day Yea	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give	e street and number)	nie.to	4b. City, Town, o	ed a le		4c. County of De	ath, MOSP
	Funeral		5. Social Security Number 6. S		(In yrs. last birth	~	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da 08/24/	1/- '	dirthplace (State or Foreign Country) entucky
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	er death with the Marylan Items 23a or 28a-f show ner must be rodified at	ctor	MD Balti	more	10c. City, Town Middle	River				1 □ Yes 21 No
	h with th	ai Dire	2205 Firethorne	Rd		10f. Zip Code 2122	20		10g. Citizen of What USA	Country?
036		To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2½ N If Yes, Give Year or Dates:		13. Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race - Ar Black, Wi Specify: W	
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JJ & m℃ Maryland 21	के द्वा क	To Be Co	17. Father's Name (First, Middle, Last) Ernest Guy				18. Mother's Nam Edith		Maiden Surname)	
-	C = W =		19a. Informant's Name/Relationship (Shirley Guy Wi			Mailing Address (Street) 5 Firethorn			er, City or Town, State Ver MD 212	
$G_{\mathcal{U}}$	m O		20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif.		cemetery	Disposition (Name of r, crematory or other pla Cremetory	^{сө)} 01/2	Date 9/04	20c. Location - City Catonsvi	
Balti	permit. Page Department of Importent: If any injury or	1 1	21. Signature of Funeral Service Licer	nsee		1211 Ches	ess of FacilityCva aco Avenu	ch/Rose e Rosed	dale Funer ale Maryla	al Home nd 21237
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P.O. P.	that the dered by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify) _				
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Division of Vital Records,	iding Physician: th. : After this certifice funeral director, p	ion: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	· Arper	ime of 28c. Injury Wo	ry at		dence 6 Other (S) how injury occurred	pecify)
Divisio	l or Attenc after death Director: I in by the	ertification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	OB Place of Init		m, street, factory, office	,,,,,	28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
*	To the Hospitel or Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of and manner sta	examination and	death occurred at the ti	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	au)		29c. Licens	-	_	29d. Date signed (Mo	nth, Day, Year)
	2		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Print)		*	1 26	04
	Sta	ate.	Dr. th omas Kr. Sand 31. Date filed (Month, Day, Year)		NKIIN 5.	quare pri	ve Bo-1+	more	mD,21232	/
- 1	Regist		JAN 2 9 20	- A	, At ,	Conti				

)4-00758 JERE HUNT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland /		rtment <i>tificate</i>			nd Me		giene Reg. N o	200	4 021	33
	Obvesiai		Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Da	y Yea	3. Time of D	eath
	Physici /Medio		Jere Joseph Hunt						Januar		2004		3 p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, To		Location of			4c	. County of De		
			513 Mitchell Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last b	inthotout	If Under 1		sters		Date of Birt			ltimore	<u> </u>
	Funeral Director		556-90-2263	Yrs.		Days	Hours	Min.	B. Date of Birt (Month, Da) FEB 22	y, Year)	952 Wa	Sirthplace (State or I Country)	Foreign
			Usual Residence of Decedent						FED ZZ	, 1:	JZ Wa	shington	
	nylan how	_	10a. State 10b. County 10c. City, Tox		cation							10d. Inside City	
	Ba-f	cto	Maryland Baltimore Upper	co	,							1 Tes 2	X∏ No
	with th	Dire	10e. Street and Number		10f. Zip C					_	izen of What	Country?	
	a 23	Funeral Director	15202 Old Hanover Road 11. Marital Status 12. Was Decedent Ever in U.S.	1 12 11	211			:-2 /5	**. V \$1-	USA		merican Indian,	
	r Item	Fun	Armed Forces?	is. vi	Yes, specif	y Cubar	n, Mexican,	Puerto R	ify Yes or No- ican, etc.)		Black, W		
e e	al', o	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No It ♣ Ses, Give Year or Dates: Vietnal	m 1	☐ Yes 2	No No	Specify:				Specify:	White	
1215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Its Hygiene of other than "natural", or fleme 23a or 28a-f show other than "natural", or fleme 23a or 28a-f show event, I'm Medical Examinat must be notified at	Completed		a. Deced	ent's Usual kind of work	done di	urina most i	of working	7	16b. K	ind of Busines	ss/Industry	
2	vithin ne. han	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT use	retired)				n . 1			
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)	rtis	an / (enter		First, Middle,			Restoration	on
Maryland 2	a la b ♥	o Be	Joseph Elwood Hunt						cille :		,		
2	2 should I and Meni is marke	၀		b. Mailin	g Address (S	Street a			Route Numbe			. Zio Code)	
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic				01d I				Uppe			21155	
e e	ges 1 at of the liftern or other		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State	of Dispos ery, crem	sition (Name latory or oth	of er place	,	Da	te	20c. Lo	ocation - City	or Town, State	
Ĕ	Pages ment of ant: If it ury or o		'4 Donation 5 Other (Specify) Metro	Cre	matory	y Ir	c . $\mid 1$	-29-	04	Ba]	timore	e, MD	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Futerel Service Licensee	22 C	Name and remat	Address 1011	Society Society	ety o	f MD.	Įnc.	152		
	40240		Edward A. Gregorchik		99 Fre						e, MD	21228	
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only the cause on each line.	Ja .	1	1 -	/			iest,	n -	Approximate Interval Betwe Onset and De	
\$	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence	of):	ميك ور	BU	Cerse	10 Va	scula		Vister	دو	
	Examiner		Sequentially list conditions.	,									
,	Sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):									
/	death certificate be executed e attending physicien and of for use as the burial-transit	Examine	resulting in death) Last C. Due to (or as a consequence	a of).									
3/60	sicien buria	dlcal E		/-									
200	g phys as the	edic	0										
ROX	th cert endin	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat	h 3 🗆	Ectopic preg	02001				1	23d. Date of d	elivery	
		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (spec						Month	Day Yea	ar
Ţ.	hat th ad by detach		Part II. Other significant conditions contributing to death but not resulting	in the un	derhina cau	so awa	o in Part I		23e Did to	bacco	so contributo	to the cause of dea	+h2
as,	requires that the een signed by th nould be detache	d by	. a.m. a.m. a.g. m. a.m. a.m. a.m. a.m.	in the dri	donying dag	30 give	THI CALL.		1			Probably 4 Unk	
Ö	law req as been 2 shou	lete							24a. Was a	10		autopsy findings ava	
итан месого	sician: The law s certificate has t lirector, page 2 s	Completed							autops perfor	sy med?	prior to	completion of caus	se of
<u>a</u>	ian: rtifica stor, p	0	25. Was case reterred to medical				26. Place o	of Death (Check only or	2 No	Ye	s 2 No	
>	Physician: this certific	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	utpatient	3□ DOA	Other			5 ☐ Reside		S XOther (Sp	ecity) SCENE	1
n or	ding Pl h. After th funeral			Time of Injury	280	. Injury	at ?	28	d. Describe h	ow injur	y occurred		
<u>s</u>	tendi leath. tor: A the fu	catl	2 Accident investigation		М		es 2 No						
DIVISION	after of Al	Certification:	4 Homicide determined 28e. Place of Injury - At home, fi	arm, stre	et, factory, c	office		28	f. Location (Si City or Town	treet and n, State,	d Number or F)	Rural Route Number	r.
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1☐ Certifying Physician: To the best of my knowledg	je, death	occurred at	the time	a, date and	place, and	d due to the o	ause(s)	and manner	is stated.	
	he Hc in 24 t he Fu pletely	edical	(Check only and manner stated.	nd/or inve	estigation, in	n my opi	nion, death	occurred	at the time, d	ate and	place, and du	e to the cause(s)	
	Vith To t	Σ	29b. Signature and title of certifier		29c. L		number		2			oth, Day, Year)	
	6		1 Cirkella				.C.M.I	c.		Jan	uary 20	3, 2004	
1	/		30. Name and address of person who completed cause of death (Item 23a)			C+~	00+ 1	D-514-4	moss	Wa-	ر تحداد	11201	
1	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Shature	111				DQTT]	more,	Mar	y Tanki	Z1ZU1	
	Registr	_	20 9. 9. 2004 Lillatura	J. J.	N A	Self.	No. of Street, or other Parkets						

		1 - For State Registrar	State of Marylar		artment of H tificate of L			ene 2001	02134
Dhypie	ion	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
Physic /Med		SIMON MATTI		MAN			JANUARY	26 200	
Exami	ner	4a. Facility Name (If not institution, give s			Bathmo	Location of Death		4c. County of Dea	ıtn
Euroro		5. Social Security Number 6. Sex	yland 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rthplece (State or Foreign ountry)
Funeral Director			M 2 F 22	Yrs.	Months Days	Hours Min.	APTII 16		waii
D .		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation				10d. Inside City Limits
Aaryla f shor	ō	Hawaii Hawaii		hoa					1 ☐ Yes 2 📆No
the A 28a-	rect	10e. Street and Number	10	noa	10f. Zip Code		10	g. Citizen of What C	ountry?
h with	0 6	14-3337 Donnybroo	k Lane		96778	3		USA	
ems ?	Funeral Director	11, Marital Status	2. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify:	White
hours af		15. Decedent's Educ	cation	16a. Deced	dent's Usual Occupa	ation	. 1	6b. Kind of Business	s/Industry
P. Pin 7.	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		kind of work done of DO NOT use retired	luring most of work)	1		
ed withygientygienty	Completed		5 +	Stude	ent	40 14-15-1-11-1		College_	
If y rail of Lick 13-0050 should be filed within 72 hours after death with the Maryland nd Mentat Hygiene. marked other than "natural", or Items 23e or 28a-f show imatic avent, Ite Medical Examinations must be notified at	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, N		
hould Mei	2	Jack Edison Hultm 19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Street a		live Han ral Route Number.	nan City or Town, State,	Zip Code)
Nical nd 2 sh ulth and 27 Is m r traum		Diane Olive Hultm		P.O.	Box 1406	Pahoa,	HI 967	7 8	
S 1 au of Hea		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other plac			Oc. Location - City o	r Town, State
mit. Pages partment of portant: If it y injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	M	etro Cr	ematory	[nc. 1-2	28-04	Baltimore	, ND
DESILITION CE, INICAL YIGHTON ZELZED COOSTO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic avent, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licent	nuc	22	Name and Address remation	Society	of MD, I	nc.	0.1.000
	7	Edward A. Gr 23a, Part 1. Enter the disease, or compli	egorchik		199 Freder	cick koac	l Balti	more, MD	21228 Approximate
B 4 8	*	shock, or heart failure. List say or Immediate Cause (Final	e cause on each line.			3,			Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death)	Due to (or as a conse	quence of):					
Examine		Constitution and disease	intracran	A d	emorrha	ce			
D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):		0			
ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	idilence of).					
ficate be executed physician and is the burial-transit	calE			4-2					
oo oo oo oo oo oo oo oo oo oo oo oo oo	ᇴ								
that the death certifued by the attending I detached for use as	lan/Me	23b. Was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel		∃Ectopic pregnancy			23d. Date of de	
e deal	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
Hecords, P.O. The law requires that the te has been signed by the tage?	ο.	Part II. Other significant conditions cor	stributing to death but not re	sulting in the u	nderlying cause give	an in Part I.	23e. Did tob	acco use contribute	to the cause of death?
w requires that been signed the should be deta	d by						1 □ Ye	24	robabiy 4 \(\sum \text{Unknown}\)
he law requires t he has been signe ige 2 should be	ete						24a. Was ar	24b. Were a	autopsy findings available
ne lav le has	ompleted						autopsy perform 1 Yes 2	ed? death?	completion of cause of s 2 No
	O	25. Was case referred to medical				26. Place of Dea	th (Check only one	1	22.10
	To B	examiner? 1 12 Yes 2 □ No	lospital: 1 Inpatient 2	☐ ER/Outpatier		4 Nursing H	ome 5 Reside	nce 6 □Other (Sp	ecify)
ing Ph		27, Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl		28d. Describe ho	w injury occurred	
Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, str		Yes 2 □No	28f. Location (Str	eet and Number or F	Rural Route Number,
UIVISION OI II or Attending Phy after death. I Director: After this	Certification;	4 Homicide determined	building, etc. (Spec	cify)	oot, factory, office		City or Town		
prita ours seral			sician: To the best of my kr ner: On the basis of examin						
To the Hos within 24 h To the Fur completely	Medical	one)	and manner stated.	- and a second second	29c. Licens			d. Date signed (Mor	
viti To	~	29b. Signature and title of certifier		e:		910			
1		30. Name and address of person who co	modeted cause of death (Its	am 23a) (Tune		710	J	anuary 2	6th 2004
10		KER THOM	J.D. 22	Soum		street		70	
s	tate	31. Date filed (Month, Day, Year)	32. Registra s Sign	nature	P. 10	,			
Regis	trar	JAN 2	9 2004 Black	W JOR	A DENTE				

			. For	State of Marylar			Health and		iene	0.01	-	
			1 - State Registrar		Ce	rtificate of	Death	Re	g. No.	UL	0 (2/35
15	Physici	an	Decedent's Name (First, Middle, Last)		т ,	II - 1 1		2. Date of Deat Month	Day	Year	3. Time	of Death A
73	/Medic	al	4a. Facility Name (If not institution, give		J.]	Hall	or Location of Deat	Januar	y Z8, Z		12	:35 ™
	Examin	er	Prince Georges			Chever		41	Princ		eora	65
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday		If Under 24 Hrs	8. Date of Birth	Year)	9. Birth	place (Sta	te or Foreign
	Director		223-32-3943	^{2□ F} 61	Yrs.	Wichting Days	Trodio IVIII.	8. Date of Birth (Month, Day, April	2,1942	Wa	sh,D	.C.
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation					IOd. Inside	City Limits
	a-f sh	tor	Md Prince G	eorges Di	stric	t Heigh	ts			į	1 □ Y	es 2⊠No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		1	Og. Citizen of V	Vhat Cou	ntry?	
	s 23e	Frai		Drive 12. Was Decedent Ever in U	10 12	2074		Consider Van or No.	USA 14 Back	a - Amori	can Indian	
"	fter de	Fune	11. Marital Status 1 Never Married 3 Married	Amed Forces?			Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	Blac	k, White,	etc.	,
036	72 hours after death with the Maryland Insturel', or Items 23s or 28s-f show disal Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:		Specify	B1	ack	
15-0	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "naturel", or Items 23s or 28s-f show other than "naturel", or Items 23s or 28s-f show ovent, the Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Bu	siness/In	dustry	
121	filed within Hygiene. Ither than "	duic	Elementary/Secondary (0-12) 1.2	College (1-4or 5+)	Bric		•		Const	ruc	tion	
d 2	should be filed within a Mental Hygiene. marked other than imatic event, the M	BeC	17. Father's Name (First, Middle, Last)		DIT	ck Lay		me (First, Middle, M				***************************************
/lar	2 should be and Mental is marked o	ToB	Richard W. Ha	11			Ida	Thomps	son			
Maryland 21215-0036	2 8 8 8	. 5	19a. Informant's Name/Relationship (Ty Lena W. Hall-Wi			-		ural Route Number,				20747
	of Health item 27 other tr		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		osition (Name of matory or other pla		District	20c. Location -			
Baltimore,	0°= 5		1 Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)			matory or other pla d Nation			aurel,			
altii	in arte	- 1	21. Signature of Funeral Service License	9 1 0	2	2. Name and Addre	ess of Facility	Service				-
8	Deg de la company de la compan	1	Kobert D	Baker fr	26	005 S.SI	nirlina	ton Rd. A	111. V	a.2	2206	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory arre	est,		Approxir Interval I Onset ar	
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		שורט כ	ANDION.	asculan	Disco	se	4.0-e	
	Examiner		1	3 41 5 5 In . 31	querice or).							
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):							
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	guence of):					_		
760,	icate be executed physician and the burial-transit	calE		300 10 (0) 40 2 00130	4001100 017.							
687	leath certificate I attending physi I for use as the I			-						-		
Вох	th cert tendin r use	an/M	23b. was decedent pregnant	3c. If yes, outcome of pregn 1□Live birth 2□Fet.		⊒Ectopic pregnanc	v		23d. Date			Wasa
O. E	the at	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5[Other (specify)	<u> </u>		Mor	าเท	Day	Year
Ω.	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th		Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	ınderlying cause gı	ven in Part I.	23e. Did tob	acco use contr	ibute to t	ne cause o	of death?
Vital Records,	quires n sign	d by	18 chemic box	uel				1 □ Ye	s 2 □ No	3 Prob	ably 4	Unknown
000	law require as been si 2 should b	Completed	Left orbove	knee an	~ nut=	U deto		24a. Was ar		Vere auto	psy findin	gs available
I B		Som	periphenal U	tascular l	Jides d	ĸ		autops perform 1 Yes 2	ned?/ d	eath?	·	f cause of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				ath (Check only one	9)			
of	Phys this ral dir	To	1 Yes 2 No	1 Inpatient 2	ER/Outpatie	III SLI DOA		lome 5 ☐ Reside			y)	
ion	Attending Is death. ector: After by the funer	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rki?]Yes 2∐No		, , , , , , , , , , , , , , , , , , , ,			
Division	r Attendi	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h		reet, factory, office		28f. Location (Str City or Town		er or Rura	l Route N	umber,
Ω	ors afforms af											
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or in	th occurred at the ti evestigation, in my	me, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and mai ite and place, a	nner as s and due to	tated. the caus	Θ(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c Licen	se number	29	d. Date signed	(Month,	Day, Year	•)
)	^		10 Inlas	Durch	ne	no.	51825		TANUAR	42	8 2	004
	• \		30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type,	, Print)	e las	0-1 H	p-4	7. 3	140	2079
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature A	4000	ا کسان د	स्य गुप	4450	, lle	44)	~ 47
	Registr		JAN 2 9 200		The American	346						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Emory Joseph Hoover January 26, 2004 5:15 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XIX M 2 F 216-12-6083 82 May 9.1921 Director Marvland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, If a Medical Examinant the notified at 1XXYes 2 No Maryland N/A Baltimore Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3838 Roland Avenue Apt. 711 21211 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status ★♥Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sign Painter Independent 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Samuel E. Hoover Pearl Viola Dix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3838 Roland Avenue Dorothy Hoover 711 Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XIX Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 1/30/2004 4 Donation 5 Other (Specify) Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): months Cancer /Medical Examiner Sequentially list conditions, I arry, locating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Ö 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 PNatural a after death. 5 Pending 1 Yes 2 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 27.64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Hou 82 Yorke 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar WAN 29

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			For State Registrar	State of Marylar		ent of Health a ate of Death		ntal Hygier	21111	+ 02137	
	Physicia		1. Decedent's Name (First, Middle, Las	= NUA-PA	HARMO	NSR.	-	Date of Death Month	22. 2564	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give		ARE P	ty, Town, or Location	of Death	RE	tc. County of Death	IA	
e.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 18 -01 -86 15 19 M 2 F 7. Age (In yrs. last birthday) 19 Months Days Hours Min. 19 Month, Day, Year) 19 Markett 3, 1920 M 19 Usual Residence of Decedent								
	Maryland -1 show	tor	10a. State 10b. County) /A	ity, Town or Location	BALTI	MORE	= CIT	7/	10d. Inside City Limits 1,☑Yes 2 ☐ No	
	th with the 23a or 28a	al Directo	10e. Street and Number 2528 CAL	VERTON HE	10f.	Zip Code	216		Citizen of What Col	untry?	
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene then "naturel", or Items 23a or 28a-f show ant, the Medical Examination mant be malified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12, Was Decedent Ever in the Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		cedent of Hispanic Or pecify Cuban, Mexica 2 No Specify		Yes or No- an, etc.)	14. Race - Amer Black, White Specify:	ican Indian, o, etc.	
215-00	nin 72 hour in "naturel Wedical E	Completed t	15. Decedent's Education (Specify only highest gradients) Secondary (0-12)	ducation	16a. Decedent's U (Give kind of life. DO NO	Isual Occupation work done during mos Tuse retired)	st of working	16b.	Kind of Business/I	ndustry	
Baltimore. Maryland 21215-0036	d la b	Be Com	12 FHGRADE 17. Father's Name (First, Middle, Last,	1 11-		LERK 18. Moth	er's Name (F	irst, Middle, Maid	en Sumame)	CURITY	
Marvia	permit, Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once.	70	19a. Informant's Name/Relationship (RMON 19b. Mailing Addr	ess (Street and Numb		* 1			
nore.	Pages 1 and nent of Healt int: If item 2 iry or other		MAYLENA HARD 20a. Method of Disposition 1 Surial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	Place of Disposition (cemetery, crematory	Vame of	Date A1-15	2 411 1	Location - City or T	$\frac{MD}{2} \frac{21216}{2146}$ Fown, State	
Baltin	permit. P Departme Importan any injur		21. Signature of Funeral Service Licer		ARRISON 22. Name	and Address of Facil	+.BR	POWNJ	R. FUNE BALTO, N	ERAL HOME 40 21217	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dea		node of dying, such as	4	espiratory arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner	_	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):								
2760 A		Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	nal	fail	mr e			months	
S Pox 68	death certific e attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of preging the second of the second o	tal death 3 Ectopi	c pregnancy (specify)			23d. Date of deli Month	very Day Year	
7 0	Se Pe	by	Part II. Other significant conditions	contributing to death but not re	esulting in the underlying	ng cause given in Part	I. 	23e. Did tobacc		the cause of death?	
Vital Record	The law requate has been page 2 should	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of	
TAN TO THE	- × × 5	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)			DOA Other: 4 🗆 N	lursing Home		6 □Other (Spec	sify)	
A S. C.		Certification;	27. Manner of Death 27. Manner of Death 28. Date of Injury (Month, Day Year) 28. Time of Injury at Work? 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 28. Date of Injury - At home, farm, street, factory, office 28. Date of Injury at Work? 28. Date of Injury - At home, farm, street, factory, office 28. Location (Street and Number or Rural Notation) 28. Date of Injury - At home, farm, street, factory, office 28. Date of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 28. Date of Injury								
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1	To the within 2 To the comple	Med	29b. Signature and title of certifier	MEDICKL	RETURN	29c. License number	17-4	29d.	Date signed (Month	n, Dey, Year)	
	141		30. Name and address of person who				. 4	3 1/11/1	Balli	21229	
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrate Sig	mastre	900 0	C CCY	1774	Dart	IVECTE, WYD	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day JAN 2004 RBUTUS 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 1G5 BURG LUTHERAN NURSING HOME SALTIMORE NIA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Days Months 1 ■ M 2 🕏 F Yrs. 10d. Inside City Limits 10c. City, Town or Location 10b. County YQ Yes 2□No 10f. Zip Code 0g. Citizen of What Country? MPFIELD 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🖾 No Specify: Specify: 16b. Kind of Business/Industry

5. Social Security Number **Funeral** 220-30-4515 Director Usual Residence of Decedent filed within 72 hours aftar death with the Marylend 10a. State ? is marked other than "natural", or flems 23s or 28s-f show traumetic event, the Madical Examiner must be notified at Director MARVLAND 10e. Street and Number Completed by Funeral 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) USTODIAN +HGRADE COMMUNITY 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pegas 1 end 2 should be filk Department of Health and Mental Hy important: If item 27 ia marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be SARAH JANE HARLES ٩ 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date BALTO, MO 21244 LAINE SHELL 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SEPH FULTON AVE BALTO, MD. 2121 40 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine attending physicien end I for use as the bunal-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to tha cause of death?

Physician

/Medical

Examiner

Physician/Medical á Completed Be ဠ Certification:

The law requires that the death certificate be axecuted cata has been signed by the a page 2 should be detached this certificata Attending Physician: i or Attending after death. Director: Aft To the Hospital or Atter within 24 hours after ded To the Funeral Director completely filled in by th

To the I

Medicai

2. bell Jof 31. Date filed (Month, Day, Year) JAN 2 9 2004 State JAN Registrar

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide 4 Homicide

29a. Certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marin 32. Registrar's Signature

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

1 ☐ Yas 2 № No 3 ☐ Probabty 4 ☐ Unknown

24a. Was an autopsy performed?

Other: 4₺ Nursing Home 5 □ Residence 6 □Other (Specify)

1 Yes 2 Mil

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

AGER

Approximate Interval Between Onset and Death

5/136

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vivien H. Hobbins **Physician** 3:32 A 01/22/2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/21/1911 9. Birthplace (State or Foreign Country) Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 92 Director 578-32-5178 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 10b. County 1 Yes 2 No Marvland Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rast ben 20904 11812 Renick Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3₩idowed 4 Divorced Year or Dates: "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12th Secretary pt.mii. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event gins. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Whelan Ireland Edwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 51 Warring Road Portsmouth Rhode Island 02871 J. Clifford Hobbins/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/26/04 Silver Spring, MD. Gate of Heaven Cem. * 4 □Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Add @ e e f 安地 P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill Maryland 211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UROSEPSTS **Physician** /Medical Due to (or as a consequence of) Examiner HYPERKALEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-transit ACUTE RENAL FAILURE The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 4No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 1 Yes XX No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗵 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; 1XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral I 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2004 30. Name and widress of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Md. White, M.D. Raymond M. 31. Date filed (Month, Da 32. Registrar's Signature State Registrar

				1 - For State Registrar			ind / Depa		Health and Death	Mental Hyg	giene leg. No. 2	004	02	140
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•		Examir	ier	GREATER BALT			CENTER	TOWSON				TIMORI	Ξ	
		Funeral				7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day 7 / 19 /	Year)	9. Birth	place (State o	or Foreign
1	SE?	Director		Usual Residence of Decedent	-X'	3	2 Yrs.			//19/	/1	Mar	yland	
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Kimberi		death ms 23	nera	11. Marital Status	12. Was Dece	dent Ever in	U.S. 13.		Hispanic Origin? (Span, Mexican, Puer	pecify Yes or No-		Race - Ameri		
a	36	or Ita	y Fui	1 Never Married 2 Married	Armed For	2 % No		1 ⊡Yes ≱⊡ XNo		to rican, etc.)		Black, White. <i>cif</i> yWhit		
9	5-0036	72 hours after natural', or Ita	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Da	tes:	16a, Dece	dent's Usual Occur	pation			Business/Ir		
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Co	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 ehow amy injury or other traumatic event, if a Medical Estri institutation and once.	ပ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru			vn, State, Zij	Code)	
		and 2		Kenneth L. Frish	key Bro	ther	1293	0 Princet	ton Rd. M	iddle Ri	ver Ma	rylan	d 2122	0
	Baltimore,	t of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from S	20b	. Place of Dispo	osition (Name of matory or other pla of Faith	ce)	Date	20c. Locatio	n · City or To	own, State	
	III III	it. Pag rtment rtant: njury		* 4 ☐Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	eify)	G		OL FaltII 2. Name and Addre		/2004	Kaspe	burg,	Maryla	and
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		/Medical Examiner		resulting in death)	Due to (d	or as a cons	equence of):							
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	×o	eath certificate be executed attending physician and for use as the burial-transit	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of preg]Ectopic pregnanc			1	Date of deliv		
	O. B	that the death ed by the atte detached for	sicia	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		int at time of		Other (specify)	,			Month	Day Y	Year
	Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending ph rat director, page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions	contributing to de	ath but not r	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use co	ontribute to t	he cause of d	leath?
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	Vita	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	Hospital: 3			Oth	DOL.	ath (Check only of			7	
	ō	y Phys ar this aral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of eath	28a. Pate o	f Injury	ER/Outpatier 28b. Time o	f 28c. Injur	ry at	lome 5 Residence 128d. Describe h			Y)	
	ion	Attending r death. ector: After by the funer	atlo	1 Natural 5 Pending investigat	on	i, Day Year)	Injury	M 1 □	rk?]Yes 2 □No					
	ivis	or Atts ifter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d Zoe Flace	of Injury - At g, etc. (Spe	home, farm, str	reet, factory, office		28f. Location (S City or Tow		mber or Rura	I Route Numi	ber,
4		To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Director: Atler th completely filled in by the funeral		29a. Certifier 1 Cartifying I	Physician: To the	best of my k	nowledge, deat	h occurred at the tr	me, date and place	and due to the c	ause(s) and	manner as s	tated.	
		the Hos hin 24 h tha Fur npletely	Medical	(Check only 2 Madical Ex	aminar: On the ba and mann	sis of exami	nation and/or in	vestigation, in my o	opinion, death occu	rred at the time, d	ate and plac	e, and due to	the cause(s)
		within To II	Σ	29b. Signature and title of certifien	1 11.	.1.	mo	29c. Licens	se number	1 2	9d. Date sig	ned (Month)	Day, Year)	
		10		77) IENEN (X HU	Su	22.12	Delan	10010	7	1/6	カクト	7	
		16		30. Name and address of person wh	SIGMI	or death (It	23a) (Type.	SIERI	DR. Suin	EGOZ	Tow	5001	MDZ	1704
		Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sig	nature							-
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31. Date filed (Month, Day, Year)

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				State of Mary		Jeparim <i>Certific</i>				giene Reg. No. 2 (106	02112	
	Physici /Medic		1. Decedent's Neme (First, Middle, Last) AUS+W BUr	2. Date of Dee Month		Year	3. Time of Death						
	Examir Funeral Director		4a. Fecility Name (If not institution, give s Maryland Ma 5. Social Security Number 6. Sex	SOUL HO 7. Age (In	MQ_ n yrs. lest bird		der 1 Year	4b. City, Town, o Cockeys If Under 24 Hr Hours Mir	s. 8. Date of Birth	4c. County Ba	of Death 1 timore 9. Birthplac Country	e (State or Foreign	
	D.		212-10-6417 Yes 96 Yes Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location						Dec 21,	1907		land	
21215-0020	a-f aho	ģ	Maryland Baltimo			ockeys	ville					. Inside City Limits 1 ☐ Yes 2 ☑ No	
	with the	Directo	10e. Street and Number				Zip Code		1	log. Citizen of	What Country	?	
	s 1 end 2 should be filed within 72 hours efter death with the Marylend f Health and Mental Hygiene. If Health and Mental Hygiene. I em 27 is marked other then "netural; or items 23a or 28a-f ahow ether traumstic event, the Medical Examiner must be inclified at	by Funeral	300 International (11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Circle 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		21030 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto			Specify Yes or No- rto Rican, etc.)	Specify Yes or No- lo Rican, etc.) USA 14. Race Black Specify:			
	d within 72 ho giene. rr then "netur r the Medical.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 08 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) \$ \$a1esman\$							16b. Kind of B			
	be filed htal Hygi ed other	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Na										
Maryland	2 should be filed and Mental Hygis is marked other aumatic event, III		William Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or F								ITNS State. Zip Co	ode)	
	1 end 2 Health a em 27 is		Eleanor R. Kemper,		682		field		Baltimore	, MD	21207		
E O	Peges 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)		20c. Location -								
Baltimore,	permit. Peges 1 end Depertment of Health Important: if Item 27 any injury or other th		21 Signatur of Funeral Service Licens		ruid	Lemmo	and Addres	ss of Facility neral Ho	1/31/04 me of Dul	aney V	alley		
1	Physician	2 1	23a. Part1. Enter he disease, or complice shock, or he art failure. List only on			ot enter the m	node of dyin	g, such es cardia		est,	Ap Int	pproximate tervel Between nset end Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Chroni	Rong	al Fo	ulme						
	pe is	liner	- 1	Chronic ATher Sc	to (or as e c	onsequence of	of): Cala	n 26	leave				
o î	execute in end iel-tren	Ехап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
x 68760,		√Medical Examiner											
. Box	death cer ne ettendin ed for use	siciar	Part II. Other significent conditions cont	tributing to death but no	t resulting in	the underlying	g cause give	en in Part I.	23b. Did to	bacco use co	ntribute to the	e cause of death?	
8, P.O	v requires that the de been signed by the e should be deteched	by Physician/I	.1				ly 4 Unknown						
Vital Records,	law require nes been sig e 2 should b	Completed b	Mo Bladder carrier.							s en eutopsy ormed? 24b. Were eutopsy findings availeble prior to completion of cause of deeth?			
ᄪ	sician: The law certificate hes t lirector, page 2 s		25. Was case referred to medical						1 □ Ye		1 □ Y€	es 2 No	
=	\$ 18 0	To Be	eyaminer?	ospital:	2 ER/Out					ath (Check only one)			
DIVISION O	ending Present. Or: After the funera	Certification:	27. Manner of Death Manner of Death Manner										
5	To the Hospital or Attending Pt within 24 hours effort death. To the Funerel Director: After the completely filled in by the funeral	Certifi								reet and Numb , State)			
	ne Hos n 24 ho ne Fune pletely	edical	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	er: On the best of my er: On the basis of exen and manner stated.	knowledge, nination end	deeth occurre or investigation	ed at the tim on, in my op	e, date and place inion, deeth occi	e, and due to the ca urred at the time, da	use(s) and ma ate end place, a	nner as stated and due to the	i. cause(s)	
	To the Comp	Ž	29b. Signature and title of certifier	0 4		2	9c. License	number	29	ed. Date signed	(Month, Dey	, Year)	
	1/X/		30. Name and address of person who con	npleted cause of deeth	(Item 23e) (T	Type, Print)	131	464		1/20	104		
	11		ROBERT LIBERTY	300 Int	true	tural	lise	le 2	1030				
E	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	AND THE REAL PROPERTY.							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death AMEND ITEM #11 PER FH G827 1/29/04 JH Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day / - /8-04 1255 AM Physician Lucille Jones /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Ridge Sykesville MD opper Carrol If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months 1□ M 2□F 83 Yrs. 577-18-9096 10-14-20 Missouri Director Usual Residence of Decedent permit. Peges 1 end 2 should be illed within 72 hours after deeth with the Meryland Depertment of Heelth and Mentel Hygiene.
Important: If them 27 is marked other than "natural", or harm and in the trainment. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Sykesv111e MD Carrol1 Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21784 5 W. Roosevelt Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 1 Yes 2 No Specify: white Completed by 30X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) å Lucy Sowrey Harry E. Norris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 W. Roosevelt Road, Sykesville, MD Patricia J. Will/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial ZCremation 3 Removal from State 4 Donation 5 Other (Specify) 1/23/04 Leola, PA Eagle Crematory 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Alaheimen Immediate Cause (Final disease or condition resulting in death) /Medical Examiner edical Certification: To Be Completed by Physician/Medical Examiner The lew requires that the deeth certificate be executed igned by the ettending physicien and be deteched for use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vitai Records, P.O. Box 68760, Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No erel Director: After this filled in by the funeral di 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ENatural 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier Red J. Mon. MA Brines Cack Or Recharden Mel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert 6. 32. Registrar's Signature 31. Dete fited (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of L			ene 2004	02144		
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death		
	Physici /Medic		Edna	D.	Jone	s		January	22, 2004	1:45P M		
}	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Deat	h	4c. County of Death			
н			Pineview Nurs	sing Home	<u> </u>	Clint			Prince Geo			
	Funeral Director		3/9-28-8/93	M X ⊠ F 94	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		^(ear) 9. Birth Cou 1909 Washi	place (State or Foreign ntry) ngton, DC		
	p ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	reation				10d. Inside City Limits		
	a-f shov	ctor										
	ith the	Oire	10e. Street and Number 10f. Zip Code 10g. Citizen of What C USA									
	s 23a	rai	9115 Marlboro Pike		Superior LL C 40	Mar December of Mi		Casaifu Vas ar Na	14. Race - Amer	can Indian		
36	d within 72 hours after death with the Maryland jiene. I then "natural", or Items 23e or 28e-f show The Madical Examitrar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2\hat{Y}\No	spanic Origin? (s n, Mexican, Puer Specify:	to Rican, etc.)	Black, White	, etc.		
Maryland 21215-0036	in 72 hou n "natura	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wo	rking	6b. Kind of Business/li	ndustry		
212	d within giene. r than "	E	Elementary/Secondary (0-12)	College (1-4or	1	ne Operat	or		IBM			
and	be file tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last) Andrew H. De	gges		•	18. Mother's Na	me <i>(First, Middle, Mi</i> V. Clark	aiden Sumame)			
ary	s 1 and 2 should t f Health and Ment Item 27 is marked other traumatic e	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
ž	and 2 alth ar alth ar 27 is ar trau		Lois Frick/Daughter	r				23 Upper M	larlboro, M	ld.20772		
ore	of Health of Health of Item 27 ir other tra		20a. Method of Disposition Y☐Burial 2 ☐Cremation 3 ☐R	emoval from State	20b. Place of Dispe cemetery, cre	osition (Name of matory or other plac	θ) 1/26	12001	Dc. Location - City or T			
Ĕ	Pages ment of ant: If It ury or o		4 □ Donation 5 □ Other (Specify)			.1 Cemeter	y <u>;</u>		uitland, Ma			
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signatur of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 2074									
8760,	Physician //Medical Examiner	ical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
.O. Box 687	The law requires that the death certificate be executed tie has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delin Month	rery Day Year		
ds, P.	uires that signed to d be deta	Ď	Part II. Dither significant continuous continuous to death but not resouring in the discerning cause given in rant i.							the cause of death? bably 4 Denknown		
Vital Records,	The law requirate has been single has been single 2 should	Completed	Baeterimi 24b. Wer an autopsy performed?									
ā		ပိ	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 eath (Check only one		2□ No		
5	Physiclan: r this certific ral director,	To B	examiner?	lospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatie	nt 3 DOA Oth		ice 6 Other (Spec	ify)			
ou of	iding Phy th. : After this tuneral c		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		TE SO DOX 4 MINING THOME SO THE			how injury occurred			
Division	or Attendate death after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best ner: On the basis of and manner si	of my knowledge, dea of examination and/or intated.	th occurred at the tin	ne, date and plac pinion, death occ	e, and due to the cau turred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)		
	ro the	Me	29b. Signature and title of certifier	. M.	. //	29c. Licens	e number		d. Date signed (Month			
	->-0		1 600 X8	Wells	er M	500	154	J	anuary 26,	2004		
	10		30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type	Print)	11 8,1	ver Spa	eing MiD	20902		
	Sta	ate	31. Date filed (Month, Day, Year)		rar Signature							
	Regist	rar	TAN 2	9 2004	Blooms A	. Gode	P					

			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment <i>rtificate</i>				giene Reg. No. 20	104	02145
	Physici /Medi		Decedent's Name (First, Middle	. ^{Last)} Elizabet	h Ann Jerda	an			2. Date of De Month Jan	ath nuary 28, 2	0 ඊ 4°	3. Time of Death 4:15 a.
A.	Examir		4e. Fecility Name (If not institution	give street and number, 9430 Dartmou		4b. City, T	own, or L	ocation of Dea	Cloumbia	4c. County		ward
	Funeral Director		5. Social Security Number 579-56-5539 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birthday) 61 Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min		th ly, Year) 18, 1942	9. Birthp Coun Wa	lace (State or Foreign arry) ashington DC
	Maryland of show	tor	10a. State 10b. County	ince Georges	10c. City, Town or Lo	ocation		Laurel			10	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28s	ai Direc	10e. Street and Number 200 Ft. Meade Rd.	Apt 804		10f. Zip 0	ode	20707		10g. Citizen of	What Coun U.S	ıtrx?
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Cheatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avent, the Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	No	_ \	nt of Hisp y Cuban, No	panic Origin? (; Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)	- 14. Red Bla Specif	e - Americ ck, White, o	
21215-0036	filed within 72 h Hygiene. other than "natu	Complete	15. Decedent (Specify only highes Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use	Occupati done du retired)	ion ring most of wo	orking	16b. Kind of B	nsiness/Ind	nustry NG
Maryland	should be fill and Mental Hy marked oth	To Be		Benjamin Taylo						Magdalen	Clokey	J
	1 and 2 sho Health and i em 27 Is ma ther trauma		19a. Informant's Name/Relationsh Mr. Richard S. Je 20a. Method of Disposytion		19b. Mailir		-	th Rd. Colu	ural Route Numbe umbia, Maryl	ar, City or Town, and 21045 20c. Location -		
Baltimore,	Pa ant ury				All County C	natory or oth Cremation	er place) n Serv	ices, Inc.	1/29/2004			Maryland
Ba	permit. Departr Imports any inji		23a. Part1. Enter the disease, or	Could W	the death. Do not ent	38	371 OI		a Pike Ellico		21043	Approximate
	Pnysician /Medical Examiner		snock, or near failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	TATIC Brossequence of):	rust C		100	Liver /	Bones	- 7	Interval Between Onset and Death
8760,	ate be executed whysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):							
P.O. Box 6	the death certific by the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic preg Other (spec				23d. Dai Mo	e of deliver	ry Day Year
	w requires that been signed to should be deta	þ	Part II. Other significant condition	ns contributing to death b	out not resulting in the u	nderlying cau	ise given	in Part I.	23e. Did to			e cause of death?
of Vital Records,		Completed							24a. Was autop perfor 1 Yes	med?	rior to com leath?	sy findings available inpletion of cause of
n of Vit	ng Phys (fter this Ineral di	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 Inpatie	ury 28b. Time of	280	Other: c. Injury a Work?	4 Nursing H	ath Check on or fome 5 Resid	ence 6 Oth	er (<i>Specity</i>)	Son's residence
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2	ot be 28e. Place of Inj	jury - At home, farm, str c. (Specify)	M eet, factory, o		s 2 □No	28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	edical C	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physicien: To the best xeminer: On the basis o and manner st	f examination and/or inv	occurred at restigation, in	the time, my opin	date and place ion, death occu	and due to the curred at the time, c	ause(s) and ma date and place, a	nner as sta and due to	ited. the cause(s)
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	Sta	te.	0. Name and address of person w 31. Date filed (Month, Day, Year)	elakos II	death (Item 23a) (Type.	Print Pot	WEE	ut Phi	wy Ca	umbu	im	D21844
	Registr	100		104 More	the state of	Es :						

			1 - For State Registrar	State of Ma		Depa		Health and	-		2001	02146
	Physici /Medio Examin	cal	Decedent's Name (First, Middle, Las Dorot da. Facility Name (If not institution, give	thy Cather street and number)		ne		or Location of Dea	2. Date of De Month JAN	27,		3. Time of Death 1:30a
lig.	Funeral Director		Heritage Genesis 5. Social Security Number 6. Security Number		e (In yrs. last bi	irthday) Yrs.	Dund			th ly, Year) 192	Baltin 9. Bir 0 Mar	nore thplace (State or Foreign cuntry) Vland
	death with the Maryland ms 23a or 28a-f show	Director	Usuel Residence of Decedent 10a. State 10b. County Maryland Baltin 10e. Street and Number		10c. City, Tow		cation undalk				izen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🕅 No
0500-61		by Funeral Director	7232 German Hill 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1	Was Decedent of H Yes, specify Cub	21222 Hispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.))-	USA 14. Race - Ame Black, White Specify:	
7-617	within 72 hours after ene. than "natural", or ite he Mudical Exterine	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)	cation le completed) College (1-4or 5	i+)	(Give life.	tent's Usual Occup kind of work done DO NOT use retire arian	pation during most of wa d)	rking		ind of Business	.,
/lang z		To Be Co	17. Father's Name (First, Middle, Last) Eugene Blum	2		JI DE	arran		me (First, Middle Catherin	, Maiden	Sumame)	rary
e, Mar)	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (T. Ronald A. Kline/S	ype, Print) ION	4	00	g Address (Street St. Mary sition (Name of	and Number or R 's Road	ural Route Numb Pylesvi Date	11e,	MD 211	32
ранитог	permit. Pages 1 Department of F Important: If tte any injury or of once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify, 21. Signature of Fufferal Service Licent)	cemete	Cre	ematory or other pla ematory,	Inc. 1/2	28/04	Ва	ocation · City or ltimore	
	certificate be executed ding physician and last as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumon Due to (or as b. Arterio Due to (or ae	ia a consequence	of):	er the mode of dying	cick Road ng, such as cardia Vascular	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 4 Days
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בי	The law ate has b page 2 sl	Completed	Seizure Disorder						24a. Was autor perfo 1 Yes		prior to death?	utopsy findings available completion of cause of 2 No
ol Vital	rding Physician: th. : After this certific funeral director,	n: To Be	27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Injui		Time of	t 3 DOA Oth	er: Nursing H	ath (Check only of dome 5 Resident 28d. Describe I	dence 6		cify)
DIVISION	To the Hospitel or Attending Physician: within 24 hours after death as a transfer to the Funerel Director: After this certifica completely filled in by the funeral director;	Certification:	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ıry - At home, fa	Injury arm, str	M 1 🗆	v.º Yes 2 □ No	28f. Location (S			ural Route Number,
	he Hospite in 24 hours he Funere pletely fille	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of iner: On the basis of and manner sta	examination ar	e, death	occurred at the tirestigation, in my d	me, date and place opinion, death occu	a, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	Y Nothi	W	29b. Signature and title of certifier	ngl	- MD	_	29c. Licens D14				e signed (Monti uary 27	- '
	Sta	ate	30. Name and address of person who c Harjit Singh, M 31. Date filed (Month, Day, Year)	.D. 5410-			Highway	Brookly.	n Park,	MD 2	1225	

	1	For State Registrar	State of Ma	aryland / De	partment of ertificate of	Health and	Mental Hyg	iene 200	
Physician	ו	1. Decedent's Name (First, Middle, Las	mes	Gerard	Kulp		2. Date of Death Month January	Day Ye	3.4
/Medica Examine Funeral Director	r S	Greater Balting Social Security Number 6. S 261–25–0280	nore Medic	al Center e (In yrs. last birthda 48 yrs.	Towson	If Under 24 Hrs	th 8. Date of Birth	4c. County of D	eeth
D		Usual Residence of Decedent 10a. State 10b. County	George's	10c. City, Town or	Location Jashington 10f. Zip Code	1	110	og. Citizen of What	10d. Inside City Limits 1 ☐ Yes ※☑ No
sath with the same same same same same same same sam	arai Dir	13418 Queens Lan	e 12. Was Decedent	Ever in 11 S 11	2074			USA	merican Indian,
JU36 ours after de	a by Funeral Director	11. Marital Status 1 № Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 ☑ If Yes, Give Year or Dates:	10	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 1 No	Specify:		Black, W	thite, etc. White
Maryland 21215-UU36 td 2 should be filed within 72 hours att th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, tra Madical Event	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)	ducation de completed) 4 College (1-4or 5	(Gi	tedent's Usual Occi ve kind of work don O NOT use retir Stems Ana	e during most of wo ed)	orking	Self Empl	,
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tra M.	o pe o	17. Father's Name (First, Middle, Last) Bernard Kulp Sr	•	10h M	III. Add Garage	Ruth A	me (First, Middle, M nn Chappe Jural Route Number,	lear	- Tin Code)
ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural; or frams 23s or 28s-1 show or other traumatic event, the Madical Examinar must be notified at	4	19a. Informant's Name/Relationship (Bernard Kulp Sr. 20a. Method of Disposition ★□Meurial 2 □Cremation 3 □	/ Father	1341	-	Lane Ft.	Washingt		land 20744
Baltimore, IV permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr		*4 Donation 5 Other (Specification of Specification of Sp	0		tion Cem.	ess offedinge	27/2004 _ P. Kalas	Funeral	Maryland Home P.A. and 20745
Physician /Medical Examiner		23a. Part. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ACV		THROID	(EUK	EMIA	rst,	Approximate Interval Between Onset and Death
ysicia e bui	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):					
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	B⊟Ectopic pregnan □ Other (specify)	су		23d. Date of Month	delivery Day Year
rdS, P	ed by Pr	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.	23e. Did tob	1.0	e to the cause of death? Probably 4 Unknown
The lay	Complet						24a. Was ar autops perform 1 \(\text{Yes} \) 2	prior death	e autopsy findings available to completion of cause of 1? Yes 2 \(\sum \text{No} \)
on of ing Phy ing Phy After this funeral d	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da		of 28c. Inj	ther: 4 🗆 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (5	Specify)
Divisio To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, et				City or Town	, State)	Rural Route Number,
the Hosp nin 24 hou the Fune	Medical	(Check only Medical Example)	nysician: To the best miner: On the basis o and manner sta	examination and/or	investigation, in my	opinion, death occ	urred at the time, da	ite and place, and	due to the cause(s)
To With	2	29b. Signature and title of certifier	M			D2773	d	ed. Date signed (M	ale
D		30. Name an address of person who	40 151		ARCET	ST. B	MITIMON	E, ho	2/204
Stat Registra	-	31. Date filed (Month, Day, Year)	9 2004 D	ar's Signature	Angell 1	-			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 27 2004 **Physician** 3:04 P Lillian Latta Teresa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Greater Baltimore Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 27 F 220-06-8922 1922 Maryland Director 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examiner must be mailfied at 1 ☐ Yes 2√2 No Directo Maryland Baltimore Dunda 1k 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 7914 Kavanagh Road by Funera 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hyglens. Important: If item 27 is marked other than 'ns any injury or other traumatic event, It a Made once. 2121 College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be <u>Teresa Schwarzkopf</u> George B. Kunnecke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7914 Kavana h Road Dundalk, MD 21222 Diane Golden/Daughter 20c. Location - City or Town, Slate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State ** 4 ☐ Donation 5 ☐ Other (Specify) 1-29-04 Baltimore, MD Metro Crematory Inc. 21. Signalure of Edneral Service ²² Name and Address of Facility Cremation Society of MD 299 Frederick Road Ba Edward A. Baltimore, MD 21228 **Gregorchik** 23a. Part1. Enter the disease, draomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final disease or condition resulting in death) Week **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No After this certificate ha funeral director, page Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check onl. one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0057926 Jan 28, 2004 wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565N. Charles St Baltmare Gordon Helen M 32. Registrar's gnature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Perry Lam 4 /Medical 4a. Fecility Neme (If not institution, give street and number) 4c. County of Deel 4b. City. Town, or Location of Deeth Examiner Baltimore N/A Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 21, 1920 Birthplace (State or Foreign Country) 5. Sociaf Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ₩ M 2 🗆 F 228-10-6534 Virginia 83 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show X¹XXYes 2 ☐ No Director N/A Maryland Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1130 W. 43rd Street 21211 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or items 11. Marital Status Black, White, etc. X Y Yes 2 □ No If Yes, Give Year or Dates: WWII filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel Productions permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygis
any injury or other *** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Seldon Lam Fannie Meadows ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 W. 43rd Street Cleta R. Lam (Wife) Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Sunal 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 2/2/04 Hampden, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road Baltimore, Maryland Pert1. Ener the disease, or complications that snock, or heart failure. List only one cause on poliste Cause (Final daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ronavu resulting in death) /Medical (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No page 2 21110 1 Yes 2 NO To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA မ 2 FNOutpatient After this funeral dir 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) only 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Physician Medical Search Name (Post Masses, Last) Alice J. Leyror Alice	Physician Alice J. Leyrer James	uary 25, 20 4c. County Balt	00 ⁴ 6:15P м
Recording Securing	## Ab. City, Town, or Location of Death ## Ab. City, Town, or Location of Death ## Ab. City, Town, or Location of Death ## About Ingham Ab. City, Town, or Location of Death Nottingham	4c. County Balt	
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D 22105 1/27/2004	D 22105	250. Date signe	m - 1 - m m 1 1
30. Name and address of person who completed cause of death (Item 23a) (Type, Print), M. S. DIDOLKAR MD Singu HOSM to A Both More Ave		23d. Date signe	2/12004
1 2 4 1 1 W BYY	State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	alt ma	21/2009 eve Ave

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	Physicia /Medic		Ida Levine								Jan.	3, 2	2004	6:0	OO AM
	Examin	er	4a. Facility Name (If not institution, give		mber)		-		Location o	of Death			County of Dea		
	F		The Hebrew Hom 5. Social Security Number 6. Se		7. Age (In v	rs. last birthday)	Roc.		If Under	24 Hrs.	8. Date of Birt		ontgon 9. Bi		te or Foreian
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	arylar show	_	MD Montgo	merv		City, Town or Lo									e City Limits Ges 2 ☐ No
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 16, 2004 **Physician** PATRICIA MICHELLE LAMBROW 10:15PM /Medical a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 3447 Hidden River View Road Annapolis Anne Arundel 8. Date of Birth Dec. 15, 1958 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 215-82-4263 Maryland 1 □ M 2**X**JX 45 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Modical Everning rrust be notified at ADDE. 1 Tes ZANo Maryland Director Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3447 Hidden River View Road 21403 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ № If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married A Married 1 Yes 2 White Baltimore, Maryland 21215-0036 ¹by• Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Interior Design 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clyde C. Anderson Patricia E. Johnson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3447 Hidden River View Rd., Annapolis, Md. Nicholas Lambrow/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-18-04 Edgewater, Md. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Furthern Server Licens 2973 Solomons Island Rd., Edgewater, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Newoendocrine cancer Immediate Cause (Final disease or condition Physician VVS resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? å 1 ☐ Yes 2 DNo 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Y esidence 6 Other (Specify) Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day Yeer) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 X Natural
2 ☐ Accident death. investigation 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mullino M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Restaute Rd. Annapolis, Md. 21401 tuair 32. Registrar's ignature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2:50 PM 2004 Vincent Anthony Leva 24 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MEALTHEARE ASNES If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F 03/11/1922 Maryland 218-14-7343 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County or 28a-f show Exactings must be notified at 1 Yes 2 No Baltimore Edmondson Heights Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5515 Forest Park Avenue 21207 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Amed Porces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 natural, or Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "neny injury or other treumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 10th Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvatore Leva Josephine Fertitta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosaria Theresa Cover / Sister 6111 Deerbrook Road Catonsville, Maryland 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral 01/29/2004 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACCIDENT-INFARCTWEERS ARDIOVASCULAR **Physician** /Medical Examiner FAILURE - PHEUMONIA WEEKS SPIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yas 2 No should be detached 9 Ulnknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ PERTENSION 1 Yes 2 No 3 Probably 4 Winknown Completed CORDNARY ARTERY DISE ASE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autoosy performed' 1 ☐ Yes certificate Viital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To o 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Completely filled Hed Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6. 15632 (MD) 2004 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) 5+1 BALTIMORE MP 21229 YCLOPEA, HNAKWI 900 AVE CATON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 2004 Jaka. Registrar

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8a-f	∄	Director	Md.	Wicomico		De	elmar	10f. Zip Code			10a Citiza	on of What Cour	ntry?
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a safe	ed ii	Ce				at home				Delmar, N			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	completely filled in by the	edical	29a. Certifier (Check only one)	1☐ Certifying Ph 2☐ Medical Exam	niner: On the ba	best of my know asis of examinat ner stated.	wledge, dea ion and/or i	ath occurred at the investigation, in my	time, date and play opinion, death of	ace, and due to the ccurred at the time,	cause(s) a date and p	and manner as solace, and due to	stated. to the cause(s)
o th o th	ошо	Me	29b. Signature an	d title of certifier				29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)
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1	5		30. Name and add	lress of person who	completed caus	e of death (Item	23a) (Type		Donn Sta	reet Ral	imor	o Maro	land 2120
		200		SHOKING	11745,1	1(1)		111	TEINI OF	reet, par	LINE	C, Fidity	
TERM _	Sta	te	31. Date filed (Mo	nth, Day, Year)	32. R	egistrar's Signat	ture	A.					1

DHMH 17 Rev 1/2001

ORIGINAL

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			For Amend Item 20b	State of Maryland per FH,G827,01/29	I / Department of Health and /04也ertificate of Death	Mental Hygie	2001. 0215
į	Physici	an	Decedent's Name (First, Middle, Last)		McClellan	2. Date of Death	Day Yeer 3. Time of Death 17/8 M
>	/Medio Examin		4a. Facility Name (Iffnot institution, give	street and number)	4b. City, Town, or Location of Dear		4c. County of Deeth
*				ins Hospital	Baltinore C	ity	N/H
	Funeral Director		5. Sociel Security Number 6. Set 212-35-1966 1C	7. Age (In yrs. Ja	Yrs. Months Days Hours Min		9. Birthplace (State or Forgign
	Maryland I ehow	tor	10a. State 10b. County	BA	Town or Location		10d. Inside City Limits 1 ☐ 1es 2 ☐ No
	h with the 23a or 28e st be not	Funeral Director	109. Street and Number James to	own Ct.	101. Zig. Code 29	109	Citizen of Whet Country?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatith and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by	11. Marital Status 1 Prever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1Yes = 2 [DNo If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 D No Specify: 	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
5	72 ho 'natur	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo		. Kind of Business/Industry
2121	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	STUCKENT		School
land	ould be fil Mental H arked oth	Be	17. Father's Name (First, Middle, Last) UNK.		Duarn	me (First, Middle, May	PIAO
Maryl	2 should be and Mental is marked of eumatic eve	2	19a Informant's Name/Relationship (T)	ipe, Print) adapted	19b. Mailing Address (Street and Number or R		ity or Town, State, Zip Code)
	1 and 2 Health a		Valerie Hender	500 - mother	5306 Jamestown (7. 104/1 Date 02/7/04 200	c. Location - City or Town, State
Baltimore,	Pages inent of Heart: If Ite		20a. Method of Disposition 1 Parial 2 Doremation 3 F 4 Donation 5 Other (Specify)	Removal from State	metery, crematory ogother place)	30-04 1	ansdowne, ms
Balt	permit. Pages Department of Importent: If it any injury or once.		21. Signature of Funeral Service Licens	W	22. Name and Address of Facility Gary P. March Fl	1270 Freq	Wilton Pass Balto, mi
	Physician		23a. Pant : Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the death. ne cause on each line.	Boain Thousky	c or respiratory arrest	Approximate Interval Between Onset and Death
J.E.	/Medical Examiner		resulting in death)	Due to (or as a conseque	To Hold		2 1
-6.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequent	100001110		Ldays
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D. Box	se death certificate the attending phys hed for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Xes 2 □ No	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
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of/	this al dii	. To	1 Yes 2 No 27. Manner of Death			Home 5 Residence	e 6 Other (Specify)
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	To the Hospitel or Attenwithin 24 hours after deatle To the Funerel Director: completely filled in by the	Medical C		sician: To the best of my know	wledge, death occurred at the time, date and plac- tion and/or investigation, in my opinion, death occ		
	To the Youthin To the comple	Me	29b. Signature and title of certifier		29c. License number	V	Date signed (Month, Day, Year)
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State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BETTY C. TONG The Johns Hoptins Hospital

31. Date filed (Month, Day, Year)

JAN 2 9 2004

JAN 2 9 2004

Baltimore MD 2287

Joyce Moore 04-00348 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State State Registrar	of Maryla		partment of F Certificate of			rgiene2 () (14 02158
		Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
Physic /Medi		Joyce	Mo	ore			Janua		
Exami		4a. Facility Name (If not institution, give street and it	number)		4b. City, Town, o	r Location of Death	1	4c. County of	Death
		4710 67th Avenue			Hyattsvi				e George's
Funeral		5. Social Security Number 6. Sex	7. Age (In yr.	s. last birtho Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	61	L	•		July 1	5, 1942	Michigan
tand		10a. State 10b. County	10c. (City, Town o	r Location			-	10d. Inside City Limits
Marylan f show	ō	Maryland Prince Georges	La	ndove	r Hills				1¥∑Yes 2 ☐ No
28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
3a o		4710 67th Avenue			2078	4		United St	tates America
deati	Funerai	11. Marital Status 12. Was Do	ecedent Ever in Forces?	U.S.	13. Was Decedent of H	·	pecify Yes or No		American Indian,
or Its			s 2⊠No		1 Tes, specify Cubi	Specify:	Hican, etc.)		White, etc.
ours in it.	ρ	3 ☐ Widowed 4 ☐ Divorced Year of	Dates:		10163 22110	Specify.		Specify:	White
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should be nd Mental marked c	2	19a. Informant's Name/Relationship (Type, Print)		19h M	ailing Address (Street			er City or Town St	nte Zin Codel
d2 s th an trau		James Moore/Husband			0 67th Ave				
1 and Health Health Sther tr		20a. Method of Disposition	20b.		sposition (Name of crematory or other place		Date	20c. Location - Ci	
Pages nent of I int: If it		1 ☐ Burial 2 【Cremation 3 ☐ Removal fro '4 ☐ Donation 5 ☐ Other (Specify)	III State			1	16/200/	D	.1
		21. Signature of Funeral Service Licensee	Γ	OIL L	22. Name and Addre	ss of Facility Bre	ntwood,	Md 20722	od, Maryland
permit. Departr Importa		100			JORT LA		FW :	3907 Blo	claub y Roll
1		23 Part1. Enter the asease, or implications that shock, or heart failure. List only one cause or	t caused the de	ath. Do not			or respiratory a	rrest,	Approximate Interval Between
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/Medical		resulting in death)	o (or as a conse	equence of):	onends	thermer	12/01	167	
Examiner		Sequentially list conditions b							
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atten for u	cian	in the past 12 months?	birth 2 Fe	tal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	
by the	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown							
igned b		Part II. Other significant conditions contributing to	death but not re	sulting in th	e underlying cause giv	en in Part I.	23e. Did t	obacco use contribe	ute to the cause of death?
The law requires that the death certified has been signed by the attending page 2 should be detached for use as	d by	remote cerebral in	tarcts	5			10	Yes 2□No 3	Probably 4. Unknown
law requir as been si 2 should I	ojete						24a. Was		re autopsy findings available
The ta	Completed							rmed? dea	or to completion of cause of http: Yes 2 □ No
	0	25. Was case referred to medical	<u>-</u> -			26. Place of Deal			165 20140
_ 8 × × 5	To B	examiner? 1 ⊠Yes 2 □ No Hospital: 1 [Inpatient 2	☐ ER/Outpa	tient 3 DOA Oth	er: 4 Nursing Ho	ome 5 Resid	dence 6200ther	(Specify) At scene
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eath.	catl	2 Accident investigation	13-04	18.1	7 M 10	Yes 2 No	subjec	(1)	,0000
or At fter d Diraci in by	Certification:	data main and 200. Pld	ce of Injury - At Iding, etc. <i>(Spe</i> c	cify)	street, factory, office		28f. Location (S	Street and Number	or Rural Route Number,
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To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune fune.	edicai	29a. Certifier 1 ☐ Certifying Physician: To the (Check only one) 1 ☐ Certifying Physician: To the and maximum.	ne best of my ki basis of examir anner stated.	nation and/o	eath occurred at the ting r investigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
o the o the o mpt	Me	29b. Si_nature and title of certifier			29c. Licens	e number	T	29d. Date signed (/	Month, Day, Year)
F > F 0		12 0 to00	of L		0.0	.M.E.		January :	14. 2004
01		39. Name and address of person who completed ca	use of death (Ite	em 23a) <u>(T</u> y					,
		PATRICIA Aronica	POLLAK	MP			, Balti	more, Mar	yland 21201
Sta		31. Date filed (Month, Day, Year) 32.	Registrar's g	nature	is speed	2			
Regist	rar	JAN 2 9 20	174 files	SEAR .	N. Johnson				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:00P M 21, 2004 January Mary Maher /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Overlea Baltimore 7404 Kenlea Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) June 22, 1914 6 Sex last birthdey) Birthplece (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours 1 □ M 2 T F 89 Maryland 215-16-0384 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County or than "natural", or teams 23a or 28a-f ahow the Madical Examinational be notified at 1 ☐ Yes 2☐No Completed by Funeral Director Baltimore Overlea 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21236 7404 Kenlea Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TVNo If Yes, Give 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify Specify: White ₩Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 6 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If item 27 fe marked oths any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Salvatore Germano Regina Maiorano 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Verna Knorr (Daughter) 3443 Merrimac Road Davidsonville, Maryland 21035 1/29 Date 2004 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore-Washington Crematory Laurel, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore, Maryland 21206
Approximate Inter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DAY INFARCTION MYOCARDIAL **Physician** /Medical Due to (or as a consequence of): **Examiner** DISEASE ATHEROSCLE ROT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed and Due to (or as a consequence of) P.O. Box 68760. the attending physician cian/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 5 Other (specify) 4 Pregnant at time of death 9☐ Unknown detached 9 Unknown been signed be should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Phknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No certificate has Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check only one Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ②No 3□ DOA 2 ER/Outpatient 28d. Describe how injury occurred 27. Magner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho
To the Fune (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 14000 rchold and address of person who completed cause of death (Item 23a) (Type, Print) 10 30. Name FRANKLIN SQUARE DR. PARSHALL 9105 32. Registrar's senature 31. Date filed (Month, Day, Year) State 2014 Com 29 Registrar

			State of Manyland / Dr	epartment of Health and Me	•	
				Certificate of Death		2000, notice
			negistrar 1. Decedent's Name (First, Middle, Last)		Reg. No. 1 2. Date of Death	3. Time of Death
П	Physici		Lydell	mack	JAN 2	Day Year In A D.
,	/Medic Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LAGITIII		The Johns Hopkins Hospital	Baltimore City	'	NIA
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe		8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
ky	Director		212-69-4310 1 [□] ZM 2□ F	s. 1 7 1	Dec. 15,2	003 Maryland
	pue ≱_		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location		10d. Inside City Limits
	Aaryli F sho	ō	Maryland NA	Baltimore Cit	tv	1 ☑ Yes 2 ☐ No
	28a-	rect	10e. Street and Number	10f. Zip Code	·	Citizen of What Country?
	3a or	ō	2812 Evergreen Avenue	21214	, , ,	U.S.A.
	death ms 2	nera		13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	rify Yes or No-	14. Race - American Indian,
9	or Ite	Fu	1 Never Married 2 Married 1 Yes 2√2No		lican, etc.)	Black, White, etc.
8	ours Frail,	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		SpecifyBlack
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-1 show ent, the Medical Examinat rusal be notified at	Completed by Funeral Director	(Specify only highest grade completed) (6	ecedent's Usual Occupation Give kind of work done during most of working	g 16b.	Kind of Business/Industry
12	within ane. then	mp	Elementary/Secondary (0-12) College (1-4or 5+)	ite., DO NOT use retired)		N/A
70	Hygie ther int,		17. Father's Name (First, Middle, Last)	18. Mother's Name	/First Middle Maide	
an	d be set o	o Be	Lydell Edward Mack, Sr.	Oiana Day		in Sumuney
<u>Z</u>	shoul nd Ma meri mati	To	L	Mailing Address (Street and Number or Rural		or Town, State, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other treumatic event, the Medical Experiment must be notified at Angles.			2 Evergreen Avenue Ba		
Baltimore,	of Hei		cometany	isposition (Name of crematory or other place)	ate 20c.	Location - City or Town, Stete
Ĕ	Page nent ant: If			Wash. crematory 1/25/2	2004 Lau	rel, Maryland
alt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mill		
<u> </u>	80 5 5 6) []]	pusica Dogy	6415 Belair Road Bal	timore, N	faryland 21206
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a Pachyayria - (EREBRAL MALFORN	MATION	Onset and Death 3 Facus
	/Medical Examiner		resulting in death) Due to (or as consequence of)	FREBRAL MALFORN	1	7-0
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	nsit	nlne	cause. Enter Underlying Cause (Disease or injury	9	<i>0</i> 0.	O .
	al-tra	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of)			
760,	eath certificate be executed attending physician and for use as the burial-transit	calE				
68			0.			
Вох	h cert andin use	M/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery
	deat ne ath	sicla	1 Yes 2 No	5 Other (specify)		Month Day Year
P. O.	at the I by the	Physician/Med	9 Unknown			
	The law requires that the death certifica are been signed by the attending ph page 2 should be detached for use as th	þ	Part II. Other significant conditions contributing to death but not resulting in the			use contribute to the cause of death?
ord	een s	ted	remutwith, severe intrai	iterine Growth	1 Yes	2. No 3 ☐ Probably 4 ☐ Unknown
Records,	has b	Completed	Restriction , Janay-Wa	lker Malformation	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
_	: The		<u> </u>		performed? Yes 2□N	death?
Vita	ysicien: The lis certificate hi director, page	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death /		
ot	Phys rthis ral dii	٠. T	1 ☐ Yes 2 No Hospital: Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim	ALIGHT 3 DOX 4 Nuising Home	e 5 Residence	6 Other (Specify)
Division of	ttending Phydeath. stor: After thi	tlon	1 Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation		d. Describe now my	ny occurred
VIS.	l or Attendate death Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		f. Location (Street a	and Number or Rural Route Number,
ā	alor At s after d al Direct ed in by	Sert	4 Hornicide building, etc. (Specify)		City or Town, Sta	le)
	ospit hour unere ly fille		29a. Certifier (Check only (Ch	eath occurred at the time, date and place, an	d due to the cause(s) and manner as stated.
	To the Hospital or Attending Physicien: within 24 hours alter death. To the Funerel Director: After this certification properties to the funerel director.	Medical	one) and manner stated.	or investigation, in my opinion, death occurred	at the time, date ar	nd place, and due to the cause(s)
	To To	2	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
1			2 rances & viorthings	DWAD 00043459	Jei	Muary 21, 2004
	The state of the s		30. Name and address of person who completed cause of death (Item 23d) (Ty	pe. Pant) dinama MID	7178	I Francis I de la
4	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	iacinote vil	2120.	I WKES North notes
	Registr	-	JAN 2 9 2004 Same	loaks/		

			1 - For State Registrar	State	of Maryla		artment of rtificate of				giene Reg. No.	2004	02161
			1. Decedent's Name (First, Mide	dle, Last)						2. Date of De	ath	V	3. Time of Death
	Physici /Medio		Frederick W M	orsberger						Month Januar	ry 27		1:15 A ^M
	Examir		4a. Facility Name (If not institution		umber)		4b. City, Town,	or Location	of Death		-	County of Death	
2		ex	3713 E Joppa 1		,		Baltimo					ltimore	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F		rs. last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Birt (Month, De	y, Yeer)	Cou	
, a	Director		215 24 0074 Usual Residence of Decedent	X	74					October	23,19	129 Balti	more, Maryland
	yland		10a. State 10b. Count	ty	10c. (City, Town or Lo	cation						10d. Inside City Limits
	e-1s	ctor	Maryland Baltin	more	Ba	altimore	County						1 ☐ Yes 2 ☐ No
	ith th	Olre	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What Cou	ntry?
	ath w	rai	3713 E Joppa Road				21236				USA	101	
	er de Itam	by Funeral Director	11. Marital Status	Armed F		U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Ori ban, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	- 1	 Race - America Black, White, 	
38	urs aff	by F	1 ☐ Never Married 2√ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, G	2 □ No ive Dates:WW I	-	1 ☐ Yes 2 🙀 No	Specify:				Specify: Whi	te
Š	within 72 hours after death with the Maryland ene. than "natural", or itama 23e or 28e-f show he Medical Examirer must ke mulified at	ted		nt's Education		16a. Dece	dent's Usual Occu	ipation			16b. Kin	nd of Business/In	dustry
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gue	2 should be filed with and Mental Hygiene, is marked other than aumatic event, the h	Be	17. Father's Name (First, Middle							(First, Middle,		Sumame)	
$\frac{2}{5}$	d Mer narke	To	Frederick W Morsh 19a. Informant's Name/Relation			405 44-70				h Pfist			
Maryland 21215-0036	d 2 sl th and t7 is r traur		Frances Morsberge				ng Address <i>(Stre</i> e 3 E Joppa						Code)
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23e or 28e-1 show any injury or other traumatic event, the Medical Examinet Trust Re notified at ance.		20a. Method of Disposition	· (MILC)	20b.	. Place of Dispo	sition (Name of	-		ate		cation - City or To	own, State
Baltimore,	Pages nent of I ant: If its ary or o		1 Burial 2XXCremation 1 Donation 5 Other				matory or other pla	1	- 27	2007	. 1		F10000#1
Ħ	permit. Page Department Important: If any injury of		21. Signature of Funeral Service		1.16	22	ematory ! Name and Addr	ess of Facilit	tv		Ealth	more, Maryl	ani
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Vital Record	has aw	Completed								24a. Was a autop perfor	sy	24b. Were auto prior to cor death?	psy findings available inpletion of cause of
a		ပို	25. Was case referred to medic	al .						1 Yes	2 A No	1 ☐ Yes	2 No
		To B	examiner?	Hospital	Innationt 2	☐ ER/Outpatien	t 3 DOA Ot	hor		(Check only or		Other (Specif)	.1
0	g Physier this	n: T	27. Manner of Death	28a. Date	of Injury oth, Day Year)		28c. Inju			28d. Describe h			//
jo	Attending r death. ector: After by the funer	atio	2	tigation	in, Day rear,	injury		Yes 2 □ I	No				
Division of	l or Attending Phatter death. Director: After the	Certification:	3 Suicide 6 Could 4 Homicide deten	mined 286. Plac	e of Injury - At ling, etc. (Spec	home, farm, str	eet, factory, office		2	28f. Location (S City or Tow		Number or Rura	l Route Number,
Ω	urs af rai D												
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the formulation of the	edicai	29a. Certifier Certify (Check only one)	ing Physician: To the I Examiner: On the I	e best of my kr pasis of examinated.	nowledge, death nation and/or in	occurred at the trestigation, in my	ime, date an opinion, dea	d place, a th occurre	and due to the c ed at the time, o	ause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certific		iner stated.	1	29c. Licen	se number		2	29d. Date	signed (Month,	Dev. Yearl
	₩ 3 ₩ 8 ₩		Muchun	VKun	how!	7,111)			-/				
	180.		30. Name and address of person	n who completed cau	se of death (Ite	em 23a) (Type,	Print)		/		1	JUT	
_	1011		9110 Phila	- 1	Ro	#31	4 8	0/+11	nin	2, m	D >	7/04	
*	Sta		31. Date filed (Month, Day, Year		Registrar's Sign		1 6						
	Registr	ar	JAN	2 9 2004	18 24 05 AW	1	Bearly 8						

		•	For State Registrar	State o	of Marylan		artment of I rtificate of	Health and N Death		iene 20 (02162
H	*	75	1. Decedent's Name (First, Middle	a, Last)					2. Date of Deal		3. Time of Death
	Physici /Medio		Frances A. Mar	ks					January	y 22, 200	3:19 p ^M
	Examin		4a. Fecility Name (If not institution	n, give street and nu	mber)		4b. City, Town,	or Location of Death		4c. County of	Death
A. C.			Greater Baltimo	ore Medica	al Cente	er	Towsor			Baltin	nore
	Funeral Director		5. Social Security Number 277–28–7490	6. Sex 1 □ M 2√2 F	7. Age (In yrs. 7		If Under 1 Year Months Days		8. Date of Birth (Month, Day, 06/30/	^{Year)} 1932 (Birthplace (State or Foreign Country) Nio
	pu .	-	Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	shor	5									1 ☐ Yes 2 No
	28a-f	Director	MD Ba 3	timore	Pa	arkvill				On Citizen of Miles	
	with a or			~ I			10f. Zip Code		'	0g. Citizen of Wha	it Country?
	eath	era	1741 Red Oak		edent Ever in U	S 13 1	21234	Hispanic Origin? (Sp	pacify Yas or No.	U.S.A.	American Indian,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural; or items 23e or 28e-f show event, I're Medical Evarning minks for notified at	by Funeral	1 Never Married 2 Marr 3 Widowed 4 XDivorced	Armed Fo	orces? 2 ⊠ No ve		f Yes, specify Cub 1 ☐ Yes 2X No	an, Mexican, Puerto	Rican, etc.)		White, etc. White
ş	2 hou	ted	15. Deceden	t's Education		16a. Dece	dent's Usual Occu	pation		16b. Kind of Busin	
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Maryland	should be filed withir in Mental Hygiene. marked other than matic event, ILLA.	2	Robert Emersor	Gore				Elizab	eth Prid	dy	
ar	s 1 and 2 should f Health and Men item 27 is marke other traumetic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	City or Town, Sta	ite, Zip Code)
	and 2		Christopher F	R. Marks (350 T	oad Hill	Road - F	ranconia	, New Hai	m shire 03580
ore.	es 1 au of Hea f item r othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation	3 Permoval from		Place of Dispo	sition (Name of natory or other pla			20c. Location - Cit	
Ĕ	Pages nent of sent: If it ury or o		'4 □Donation 5 □ Other (S			tro Cre	ematory,	Inc. 01/2	27/2004	Baltimor	e, Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service	Ligensee							ral Home, P.A.
m —	\$0 E E 9		C. A.S.	ssedn		11	750 Bela	ir Road —	Kingsvi	lle, MD	21087
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PN	EVMON	11 A					Onset and Death
	/Medical		resulting in death)	Due to	(or as a conseq	uence of):					(01)
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8760	cate be executed physician and the burial-transit	dicai		d							
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Box	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live I	tcome of pregna pirth 2 ☐ Feta	ıl death 3 ☐	Ectopic pregnanc	у		23d. Date of Month	f delivery Day Year
O	0 0	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregi 9□Unkn	nant at time of d lown	leath 5	Other (specify) _			TO THE	buy tour
٦.	The law requires that the de ate has been signed by the a page 2 should be detached t	Ph)	Part II. Dther significant condition	ons contribution to d	eath but not rec	ulting in the u	aderhing cause on	on in Part I	23a Did toh	acco use contribu	te to the cause of death?
Vital Records,	ires tha signed I be del	þ	Tarrii. Dallor significant contain	in a contributing to a	oatii Dat ilot ios	catarig in the di	ilderlying cause gr	veri ili Fait i.	1 □ Ye	10	Probably 4 Unknown
5	w requir been si should I	etec								2 2 2 1 10 0	
င္	e law has b	Completed							24a. Was ar autops	y prior	e autopsy findings available to completion of cause of
=	The	Ö							perform 1 ☐ Yes 2		th? Yes 2□ No
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Sio	tend leath tor: / the f	cat	2 Accident investig	not be				Yes 2 □No			
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	urs a		One Complete	- Dh. sisis - T. II	Land of our land						
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 17 Certifyir 2 Medical	g Physician: To the beaminer: On the b	a best of my kno basis of examina iner stated.	tion and/or in	vestigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	luse(s) and manne ate and place, and	or as stated. due to the cause(s)
	ithin of the or	Me	29b. Signature and title of certifie		L		29c. Licens	se number	25	9d. Date signed (M	fonth, Day, Year)
	F 3 F 3		LA Tol		\mathcal{N}		D	27730		. 7.	104
			30. Name and address of person	who completed care	V ▼ se of death (Iton	n 23a) (Type	Print)	· //	A-10-		t I
	N		GARY CON	en My.	6569	N. CLA	RIE ST	1/130	TIMORE	, 40	21224
	Sta Registr		31. Date filed (Month, Day, Year)	2 9 2004	A Comment	130	Broke				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 2:15 Pim. **Physician** Anuan County of Deeth J. Markowski 4a Fecility Neme (If not institution, give street end number) /Medical Examiner inie ma North Arandel
5. Social Security Number 6. S MOSpita Arund e If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months 272 Yrs. 222.18.4016 Director Delaware Usuel Residence of Decedent 10d. inside City Limits 10a. Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Marical Examinat must be notified at 1 Yes 2 No Hanover Anne Arundel MD **Funeral Director** 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21706 19 Greenknoll Boulevard 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
11 Yes, Give 1 ☐ Never Merried 2 ☐ Married White 3altimore, Maryland 21215-0020 Specify: Be Completed by 3 Widowed 4 □ Divorced ear or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Finance Elementery/Secondary (0-12) College (3-4or 5+) Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Mary Radka Stanley Markowski END ANIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19 Greenknoll Blvd. Hanover, MD 21706 Mr. Charles A. Martin, III Brother-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Ognation 5 □ Other (Specify) 01/29/2004 Wilmington, DE All Saints Cemetery 22. Name and Address of Fecility Krienen-Griffith Funeral Home, Inc. 21 Signature of Funeral Service Licenses 1400 Kirkwood Highway Wilmington, DE 19805 11100533 Pert1. Enter the discrese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner SCOSCOS Physician/Medical Examiner To the Hospital or Attending Physician: The lew requiras that the death cartificate be asscuted within 24 hours after deeth.

To the Funeral Director: After this certificeta has been signed by the attanding physician end completely filled in by the funerel director, paga 2 should be datached for use as the buriet-transit or Attending Physician: The lew requires that the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2X No 3 □ Probably 4 □ Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 201 No Other: Hospital: 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes Inpatient 3□ DOA 27. Manner of Death 1 Matural 2 Accident 28a. Date of injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner steted. 29a. Certifier 29c. License number 29b. Signeture endytitle of certifier 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 32. Begistrer's Signature 31. Dete filed (Month, Day, Yeer) State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:00 A M January 24, 2004 Niederhauser Robert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dunda1k Baltimore Genesis Eldercare - Heritage If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 XM 2 □ F 212-09-8788 96 1907 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County r then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No XX MD Baltimore Dunda1k Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7232 German Hill Road 21222 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give X 11. Marital Status 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Machinist Koppers Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Henry Niederhauser Catherine Hunt 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Niederhauser (Son) 2262 Souththorn Road Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 1/27/04 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. Megalith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Between onset and Death On Immediate Cause (Final in health **Physician** recline disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner brillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit ailure Chronic Illness Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 BUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Medical Certification: To 27. Manner of Death 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury 5 Pending 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0005985 HOSP POB 303 Good Sanaritan who completed cause of death (Item 23a) (Type, Print) 30. Name and ad Baltimore nao, rilpalix 31. Date filed Month, Day, Year) 32. Registrar's Sign State 9 2004 Registrar

			1- For Amend Item 1 per Dr. Registrar	ate of Maryland / .,G828,02/27/04d	Depa lhb	artment of Hetificate of D	ealth and Death	Mental Hyg	iene 20	04 02165
I	Physici	் an	1. Decedent's Name (First, Middle, Last)	Tyevi		01iver		2. Date of Deat	h Day Y	3. Time of Death
	/Media	al	40 Facility Name (If not institution with a street	CHVEV		45 Ch. T		LIMUCI	Mar 2	004 2237 M
	Examir	er	4a. Facility Name (If not institution, give stree	and number)		4b_City, Town, or	Location of Dec		4c. County of	timore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last I		If Under 1 Year Months Days	If Under 24 Hr	s. 8 Date of Birth	Vanel 9	Birthplace (State or Foreign Country)
	Director		212.28.4799 10M	2 F 7	2 Yrs.	Months Days	Hours Mir	Month, Day,	- 31	Country) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c_City, To	wn or Lo	cation				10d. Inside City Limits
	Mary B-f sh	ţo	MD BACtim	ore Ran	dal	Stown				1 ☐ Yes 2 🖾 No
	ith the	Funeral Director	10e. Street and Number			10f. Zip Code		16	0g. Citizen of Wha	it Country?
	s 23a	rail	6 Cinnamon Circ	le APT 26	3	2113			USA	
	tter de r Item inerr	Fune	Α Α	/as Deceden't Ever in U.S. med Forces? □ Yes 2 127 No	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		American Indian, White, etc.
036	ours a	by	3 ☐ Widowed 4 ☐ Divorced	Yes, Give ear or Dates:	1	☐ Yes 2 1 No	Specify:		Specify:	Black
2-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Exeminal must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade con	n npleted)	(Give I	ent's Usual Occupat	ion iring most of w	orkina	16b. Kind of Busin	ess/Industry
121	within ene. than	Jumo	Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. D	O NOT use retired)				
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Maryland 21215-0036	uld be Mental irked c	ToB	Luther R. Jenk.	ns			Mas	ie Koi	•	
lan	2 should and Men is marke	i	19a. Informant's Name/Relationship (Type, F	rint) 19	b. Mailin	g Address (Street ar		iural Route Number,	City or Town, Sta	te, Zip Code)
	1 and 4ealth em 27 thar tr			Husband 2		Kiverway	CTA	7 102 00	wingsmill	s, mo 21117
200	Pages 'nent of thint: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove	al from State	ery, crem	sition (Name of atory or other place	1		20c. Location - Cit	
altimore,	artme ortani injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Garri	50M	FOSES7 Name and Address	of Facility V	18-04 C	Wings M	i'LLS MD
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	*		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	ns that caused the death. Do	not ente	r the mode of dying,	such as cardia	ic or respiratory arre	st,	Approximate Interval Between
9	Physician		Immediate Cause (Final disease or condition	IKCVD						Onset and Death
	/Medical Examiner		resulting in death)	Due (or as a consequence	e of):	12.01				
ď	W. Mark &	e.	Sequentially list conditions, if any, leading to immediate	Due to or as a consequence	e offi	LLEO'				
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
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8760	death certificate be executed e attending physician and id for use as the burial-transit	dical	d							
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	death e atter	iciar	in the past 12 months?	Live birth 2 Fetal deat Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
O.	at the I by th stache	hys	9 🗆 Unknown	Unknown						
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Ke	9 4 9	Completed						24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of
Vital Records,	ician: Th certificate rector, pag	a)	25. Was case referred to medical				Of Place of Do	1□ Yes 2	DNo 10	Yes 2□No
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n of	ng fferi		27. Manner of Death 1 ☐ Hatural 5 ☐ Pending	a. Date of Injury 28b. (Month, Day Year)	Time of Injury	28c. Injury a Work?		28d. Describe how		
<u> </u>	or Attending ifter death. Director: After in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	Discontinuo Attaura			s 2 No			
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X	pspita hours meral y filled		29a. Certifier 1 ✓ Certifying Physician	: To the best of my knowledg	ge, death	occurred at the time	, date and plac	e, and due to the cau	use(s) and manne	r as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical	one) 2 medical Examiner: C	on the basis of examination a nd manner stated.	nd/or inve	estigation, in my opir	nion, death occ	urred at the time, dat	e and place, and	due to the cause(s)
	with To Con	2	29b. Signature and title of certifier			29c. License		29	d. Date signed (M	onth, Day, Year)
1	M.s.	1	20 Name and add the Country of C	av lee er			1339		KINUCIN	120,2004
	e se	Î	30. Name and address of person who completed by Leillici Hill (a.)	ed cause of death (Item 23a)	(Type, P	(201. Re)	udulls	our int	21133	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	1	books		V '>		
	Registra	ar	JAN 2 9 2004	Derse /	1	gover				

		1	For State Registrar	State o	f Maryland		artment rtificate				F	leg. No.	2004	0216	6
	Physicia /Medic	ın	t. Decedent's Name (First, Midd Joseph Bryan O								2. Date of Dea Month	Day 20	2004	3. Time of Death	
	Examin	er	la. Facility Name (If not institution Mariner Hea	1th of	Bel Ai		4b. City, T Bo	11	ocation of		8. Date of Birt	H	ar Ford	d	aign
	Funeral Director		5. Social Security Number 216-16-6142	6. Sex 1. 1 M 2 □ F	7. Age (In yrs. la		Months	Days	Hours	Min.	April 1	v, Year)	1923 M	nplace (State or Fore untry) Aryland	
	show	_	Usual Residence of Decedent 10a. State 10b. County			Town or Lo								10d. Inside City Lim 1 ☐ Yes 2 🛣	,
	ith with the Maryla 23a or 28a-f shovest be notified at	Directo	MD Har 600	ia	De	X AVI	10f. Zip (Code				10g. Citiz	en of What Co	untry?	
36	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be nutified at	by Funeral Director	1110 Vale Road 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 ☐ Yes	2 X No ive		210 Was Decede If Yes, speci	ent of His fy Cuban	spanic Orig n, Mexican, Specify:	in? (Spec Puerto P	city Yes or No- lican, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.	
215-00	ithin 72 hou ne. nan "natura ne. Woolcal E	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)	(1-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use	k done di e retired)	tion uring most	of workin	g		nd of Business/		
land 21		To Be Col	17. Father's Name (First, Middle Munice C. Osbo)			vai	ry Fa				(First, Middle,	Maiden .		wem	
Baltimore, Maryland 21215-0036	r 23 Filt		19a. Informant's Name/Relation Eleanon B. Osbo 20a. Method of Disposition 1 🛮 Burial 2 Cremation	orne/ Wife	20b. Pl	P. ace of Dispermetery, cre	0. 10 osition (Nam	66 B	el Ai	л, М 01-2	Route Number D 21014 ate 5-2004	20c. Lo	Town, State, a	Town, State	
Baltimo	permit. Pages 1 a Department of Hec Important: If item any injury or othe once.		*4 □ Donation 5 □ Other (21. Signature of Funeral Service	Specify)	We!		tingho 2. Name and		emete	ry	,			Maryland Home, P.A 21911	
ome se	Physician // Medical Examiner The private transit tra	dical Examiner	23a art1. Enter the isease, shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, is an in the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	o (or as a consequence of (or a))).	O Va Sence of):	icu la		Ac	cid	ent			Approximate Interval Between Onset and Death WHAIR hou	OM
OS bo 0. Box 68	that the death certifical ed by the attending photelached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregna birth 2 Fetal gnant at time of de nown	deeth 3	□Ectopic pro						23d. Date of de Month	livery Day Year	
٥	v requires that the bear signed by should be detact	d by Pr	Part II. Other significant condi	tions contributing to	death but not resu	ulting in the	underlying ca	ause give	en in Part I.			obacco u Yes 2		o the cause of death robably 4 DUnkno	
of Vital Records,	The law req ate has beer page 2 shou	Complete	Diabeti	s Me	litus						24a. Was auto perfo 1 \(\text{Yes}	psy prmed?	prior to death?	utopsy findings availa completion of cause s 2 2 2 10	able of
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OSEPH	al or Attandi s after death.	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	minord 288. Flat	ce of Injury - At ho Iding, etc. (Specif)	ome, farm. s	treet, factory	r, office			28f. Location (City or To	Street an wn, State	d Number or A	ural Route Number,	
7	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	Medical	(Check only 2 Medic		he best of my kno basis of examina anner stated.	wledge, dea tion and/or	nvestigation	, in my o	ne, date an pinion, dea e number	d place, ath occurr	and due to the ed at the time,	date and	and manner a d place, and du te signed (Mon	e to the cause(s)	
	With To	2	29b. Signature and title of certi	14	m			DI	958	23		-	iyary	20,00	04
	10		30. Name and address of pers	2 M.	use of death (Item	72	e, Print)		8	s Le	RW ST	tre.	et / 1	Aberde	en
	St Regist	ate trar	JAN	2 9 2004	State Same	100	Spark	20			ŕ				

			For State Registrar	State of Maryla	nd / Depa			Mental Hyg	iene	004 0	1216
	Physici	an	1. Decedent's Name (First, Middle, Last	D11511 0=				2. Date of Deat Month	h Day	Year	ne of Death
1 4	/Medi Examir	cal	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	/ -	4c. County of		25 PM
	Zami			24		BACT.	more				
r	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs	s. last birthday) 82 Yrs.	Months Days		8. Date of Birth (Month, Day,	Year)	9. Birthplace (Sta Country)	ate or Foreign
	D.		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	ocation			7	10d focia	de City Limits
	Maryla of sho	to	mo	12	111	nore					Yes 2 No
	or 28a	Direc	10e. Street and Number		<i>)</i> , , , , , , , , , , , , , , , , , , ,	10f. Zip Code		10	Og. Citizen of WI	hat Country?	
	death with the Maryland rms 23e or 28e-f show	Funeral Director	0800 Cibe(ty Ro	12. Was Decedent Ever in	U.S. 13.	Was Decedent of	Hispanic Origin? (So	ecity Yes or No-	U.S.	- American India	0
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Exp. till set restling at any injury or other traumatic event, the Madical Exp. till set restling at ance.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	Rican, etc.)		, White, etc.	k
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212	d within piene. rr than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	6000	DO NOT use retir	eman		Water	Front	-
	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)		~)	18. Mother's Nam	e (First, Middle, M	laiden Sumame		
Maryland	should nd Men marke imatic	2	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	na Address (Stree	t and Number or Rur			tate Zin Code)	
	and 2 salth ar n 27 is er trau		Lillian H. PHillip	s/wife	6800	Ciberto	1	. 1	,	MD 21	207
Baltimore,	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition 1 ØBurial 2 □ Cremation 3 □ F		Place of Dispo	sition (Name of / matory or other pla		Date 2	Oc. Location - C	ity or Town, State	ө
altin	permit. Pa Departmer Important any injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		00d/Awr	n <i>Cemete</i> 2. Name and Addr	ess of Facility Que	0-04 Jehn . 6-14	SALTIN	WIE MI	o ces
m	Depa Impo any ii	1.29	Naceyla C. Yu	eere	8	728 Cib	erty Rd	Randalls	1000000	no 2113	3
			23a. Part1. Enter the disease, or complete shock, or heart failure. List only of immediate Cause (Final	cations that caused the dea ne cause on each fine.	ath. Do not ent	ter the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approxi Interval Onset a	mate Between and Death
Ä,	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):	RUCTI	VI PI	VEUNO	NIA		-
133	Examiner)ť	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	-64-L	NON	SMALL	ELL LUN	in topicon	Apid	
	ate be executed hysicien and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	METRIST	MSES	TO LI	/FQ An	D KIDA	EYS	Ĭ	
760,	le be execul ysicien and e burial-trar	cal E		ASING.	quanca oi):	LING	- DISERTE				
89	ertificat ing phy e as th		tF FEMALE:						1		
.O. Box	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnand Other (specify)	су		23d. Date Monti	-	Year
۵.	ss that gned by	by Pt	Part II. Other significent conditions con	tributing to death but not re	sulting in the u	nderlying cause g	ven in Part I.	23e. Did toba	acco use contrib	ute to the cause	of death?
ord	w requires that been signed k should be det	eted	TYPESTER	SION OF	FO ACT	10.08		1 🗌 Yes	2 □ No 3	Probabfy 4	nknown
Vital Records,	ician: The law certificate has rector, page 2 t	Completed	DECENT	ALIVE US	LUARY	HTITIO		24a. Was an autopsy perform	ed? pri	ere autopsy findir or to completion ath? Yes 2 No	igs available of cause of
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ospitaf: 1 ☐ Inpatient 2 ☐] ER/Outpatien	nt 3 DOA Ot	26. Place of Deatl	me 5 Resider		(Specify)	
0 0	ding Phys n. After this funeral di	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	iry at ork?	28d. Describe hov			
Division of	Attending or death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of frierry - At I	nome, farm, stre]Yes 2□No	28f. Location (Stre	et and Number	or Rural Route A	Jumber
Š	rs after al Dire	Certification:	4 G Normalde	building, etc. (Spec	ity)			City or Town,	State)		,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medicel Exemi	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	n occurred at the to vestigation, in my	ime, date and place, opinion, death occurr	and due to the cau ed at the time, dat	use(s) and mann e and place, an	ner as stated. d due to the caus	se(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and marrier stated.		29c. Licen	se number	29	d. Date signed (Month, Day, Yea	r)
	\cap		1 /mkluenos	₩			1303	100	6/10	18/30	104
	1		30. Name and address of person who co	mpleted cause of death (Ite	10	Print)	o Leres 1	B/4/1	NORED	ONE A	M) 1761
	Sta Registr	- 7	31. Date filed (Month, Day, Year)	32. Registrar's Sign	atura	. H. A.	hade				Mary

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. < 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 24 10:05 pm 2004 PAULINE ROUT PEAKE January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner STELLA MARIS @ MERCY HOSPITAL BALTIMORE N/AIf Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1□M 2♥F Director -28-1946 243-78-4169 NORTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic evant, the Medical Examiner must be notified at 11 Yes 2 □ No BOWIE MD. PRINCE GEORGE Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3649 ELDER OAKS BLVD. 20716 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--0-ASSEMBLY PERSON PAPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be nant of Health end Mental REV. JOHN HENRY ROUT SALLIE LOU ANDREWS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RODNEY PEAKE (SON) 3649 ELDER OAKS BLVD. BOWIE, MARYLAND 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Oremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) VIOLET HILL CEMETERY 1-27-2004 ASHEVILLE, N.C. Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Facility RAY & ALLEN FUNERAL SERVICE, INC. 127 McDOWELL ST. ASHEVILLE, NORTH CAROLINA 28801 Such Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medicai Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ene Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) \\OS\()(C 1 TYes 2PTNo 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, this Certification:

Baltimore, Maryland 21215-0020

Peake, MauLine

Director: A within 24 hours a

To the Funeral C

complataly filled

edicai 29b. Signature and title of certifier

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 I Homicide

(Check only one)

31. Date filed (Month, Day, Year)

n State Registrar

5 Pending investigation

6 ☐ Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sebera

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

1 ☐ Yes 2 ☐ No

_			1- For Amend Item 15,17 State of Manyland Department of Health and No. 27,01729 Certificate of Death	R	eg. No.	, 5410,7
4.	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth T. Ross AKA Frances Elizabeth T. Ross	2. Date of Deat Month	Day Yeer	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	January	26 2004 4c. County of Deat	h
	Karin se aposesi	9 11	6620 Marott Dr. Lochearn		Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Annual Property of the Proper	8. Date of Birth (Month, Day,		hplece (State or Foreign
	Director		Usual Residence of Decedent	08/25/19	30 Virg	inia
	nylanc how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-1 e	cto	Maryland Baltimore Lochearn			1 ☐ Yes 2 🔀 No
	with th	Dire	10e. Street and Number 10f. Zip Code		0g. Citizen of What Co	untry?
	eath is 23	era	6620 Marott Drive 21207 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		S.A.	rican Indian.
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "netural", or Items 23e or 28e-f show ery injury or other traumatic event, the Medical Examinar must be notified at ODEs.	by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Pueric	Rican, etc.)	Black, White	
. 00	uraf',	d b			Зреспу.	
55	n 72 h	lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/	industry
2055 21215-0036	withii piene. r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Worker		Social Ser	vice
	al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last) Thaddeus L. Thornton Sr.	ne (First, Middle, A	fleiden Sumame)	
€ T H Maryland	Menta Menta arked atic e	10	Thaddius L. Thornton Sr. Mary J.			
Mar	2 short and I muraum		19a. Informant's Name/Relationship (Type, Print)Brother 19b. Mailing Address (Street and Number or Rur		•	
	1 and Health em 27		Thaddeus L. Thornton Jr. 3143 Jeffrey Road, Woo 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)		aryland 21 20c. Location - City or	
2.F	ages ant of t: If it y or o		1 Seural 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Mem. Pk. Ceme. 02/0		altimore,	
にしてみら Baltimore,	mit. Poartme	Ī	21. Signing of Funeral Service Livisee 22. Name and Address of Facility The	Derrick	C. Jones H	7/H. P.A.
1) W	Deg e de		4611 Park Heights A	Ave., Bal	timore, Ma	
2			23a. Part 1. Enter the disease, or complications that caused he deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARC	TION		Onset and Death
	/Medical Examiner		Due to (or as a consequence of): COROWARY ARTERY	71	SEASE	
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	01.	301130	
	ate be executed hysician and the burial-transit	Examiner	that initiated events C.			
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
387	physi s the t	dle	d			
Box 6	eath certific attending p for use as	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	ivery
	death le atte	Physician/Medical	in the past 12 months? 1 Yes 2 No 1 Heleans		Month	Day Year
P.0	that the de led by the a detached t	Phys	9 Uurknown			
S,	es ti igne	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	obably 4 Dunknown
Sor	law requires as been sign 2 should be	etec				
Rec	has be 2	Completed		24a. Was ar autops perform	y prior to death?	topsy findings available completion of cause of
tal	icien: Th certificate rector, pag	0	25. Was case referred to medical 26 Place of Deat	1 ☐ Yes 2 th (Check only one	No 1 Yes	20 . Mo
Ž	S 0 =	To B	examiner? 1 Set 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Hospital: 2 ER/Outpatient 3 DOA			city)
0 1	ng Pt	:uo	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work?	28d. Describe ho		
Isio	Attending Phy r death. ector: After thi by the funeral o	cat	2 Accident investigation M 1 Yes 2 No	29f Location (Ct	unnt and Mirmhad as Co	South March
Division of Vital Records,	lor At after of Direction by	Certification;	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Ru , State)	rai Houte Number,
49	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur.	and due to the ca	use(s) and manner as	steted.
4	the Hin 24 the Fi	Medical	one) and manner stated.			, , ,
	with To	~	29b. Signature and title of certifier 29c. License number	29	od. Date signed (Month	OO (
	15		20. Name and address of person who completed cause of death (Hem 23a) (Tuno Print)		-1.0	004
	J.	4.	30 Nami and address of person who completed cause of death (Item 23a) (Type, Print) FRANCES CO GRASSO M5 6569 M. CHA 31. Date filed (Month, Pay, Year) 32. Registrar's Signature	RUES S-	T TOWS	ON
	Sta Registra		31. Date filed (Month, Pay Year) 2004 32 Registrar's Signature			

Physicia		 Decedent's Name (First, Mide 									2. Date of Dea		200 Yea		Time of C	eath
		Fr	ancis	M. F	Rumney						Janua				:43	P
Medic/ Examino		4a. Facility Name (If not instituti	on, give stree	t and numbe	or)		4b. City,	Town, or	Location o	f Death		4c. C	County of De	ath		
		1270 James St						imor	e If Under 2	0.4 Hrs	D D-4 (Di-		0.5	irthplace ((Ctata as	Com in
uneral		5. Social Security Number 212-58-7277	6. Sex 1 ∑ M		Age (In yrs. 54	last birthday) Yrs.	Months		Hours	Min.	8. Date of Birl (Month, Da Dec • 7	y, Year) • 194		Country)	_	roreig
rector	-	Usual Residence of Decedent									DCC. /	, 13-		KAL Y LO	111.4	
Mot		10a. State 10b. Coun	ty		10c. Cit	y, Town or L	ocation								side City	
28e-f show	cto	Maryland				Balt	cimore	9							CXYes 2	2 [] No
or 28	Director	10e. Street and Number					10f. Zip	Code				10g. Citiz	en of What	Country?		
		1270 James S			. =	0 10			L223	-:-2 (C	offer Van as No		nited 4. Race - A			
ttems ner m	Funeral	11. Marital Status	, , , , , , , , , , , , , , , , , , ,	Was Deceder	s?	.5. 13.	If Yes, spe	cify Cuba	in, Mexican	, Puerto F	cify Yes or No Rican, etc.)	. '	Black, W		uiaii,	
r, or	by F	1 ☐ Never Married 2 ☐ Midowed 4 ☐ Divorce	ed	Yes 2[Yes, Give Year or Dates	s:		1 🗆 Yeş	2 X No	Specify:			3	Specify:	White	9	
급명		15. Deced	ent's Education	on (=1=4)		16a. Dece	edent's Usu	al Occup	ation	t of working	20	16b. Kin	d of Busine	ss/Industry	,	
5.0	Completed	(Specify only high Elementary/Secondary (0-12		College (1-4c	or 5+)	life.	DO NOT	ise retired	during most 1)	OI WOIKII	, y	Dubl	ic Wo	rka		
른쪽	Con	12				Supe	ervis	or						TV2		
avent,	Be (17. Father's Name (First, Middle		orr Tr	_						(First, Middle,		Sumame)			
marked c	ို	Robert Mannin			· ·			/24			. Heal		Town State	. Zie Code		
- E		19a. Informant's Name/Relatio									Route Number			s, zip code	7/	
Important: If item 27 any injury or other tra		Christina Rumn 20a. Method of Disposition	iey - w	ille	20b. F	Dace of Disponentery, cre	York osition (Na				Maryl		ation - City	or Town, S	State	
- T tt	1	1 ØBurial 2 ☐ Crematio		oval from Sta	110	cemetery, cre wnsvi]				1/30	/04	Crown	svill	○ M=	. Prez 1 :	and
ortant: injury 8.		*4 □Donation 5 □ Other 21. Signature of Fuperal Privio		7.7	CIC	2	22 Name a	nd Addre	ss of Facilit	v -						
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	1	23a. Part1. Enter the Usease, shock, or heart failure. L	or complication	ons that caus	sed the deal								, , , , , , , , , , , , , , , , , , , ,	Appr	roximate rval Betw	
ledical aminer		disease or condition resulting in death)	(a		sclerot	ic Card	i.ovasc	ular 1	Disease	<u> </u>				Onse	et and D	eatn ——
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ruby De Rossett 2004 Jan. 24, 4:21 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heritage Elder Care Baltimore Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛱 F 86 213-28-9490 May 4, North Carolina Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rai", or items 23e or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7732 German Hill Road 21222 United States Pages 1 and 2 should be filed within 72 hours after death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married natural, or Baltimore, Maryland 21215-0036 1 Yes 200 No Specify: Specify: White If Yes, Give Year or Dates: 3X Widowed 4 □ Divorced permit. Pages 1 and 2 should be illed within 72 ht Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other treumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jacob Stewart Palestine Leopard ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlie Stewart/Son 605 Rockaway Beach Ave. Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 01/29/2004 Maltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bradley-Ashton-Matthews Funeral Home, Inc.
2134 Willow Spring Road Balt., MD 21222 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cauca Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1⊟ Yes 2XX No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 2 ER/Outpatient 3 DOA in by the funeral 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending investigation М 1 Yes 2 No death. after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled i within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 9 2004 Registrar

			State of Maryland / Department of Health and 1- State Amend Item 5 per FH,G828,02/05/04dhb Certificate of Death		iene 2004 02/72
	Physici	an	1. Decedent's Neme (First, Middle, Last) ALEVANISH MIDER M. ROSE R.	2. Date of Death	Day 7 Yeer / 9 11/ 14
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ith	4c. County of Death
	LXdiiiii		MD, GENERAL HOSPITAL BALTIMO	RE	NIA
	Funeral Director		5. Social Security Number 6. Sex 10 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min		Year) 9. Birthplace (State or Foreign Country) VIRGINIA
	pur *		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	/	10d. Inside City Limits
	Maryli f sho	tor	MARYLAND NIA BALTIMO	RE CL	1 ☑Yes 2 ☐ No
	or 28a	Directo	10e. Street and Number 10f. Zip Code		0g. Citizen of What Country?
	eth wi	raiD	1712 THOMAS AVENUE 212	16	USA.
	ter de items inerii	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puel	Specify Yes or No- nto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	72 hours after deeth with the Maryland natural', or items 23a or 28a-f show itsal Exarchive I neal be notified at	þ	3 □ Widowed 4 ☑ Divorced If Yes, Give 1 □ Yes 2 ☒ No Specify:		Specify: BLACK
5-0	s 1 and 2 should be filed within 72 hours after deeth with the Marylan I Health and Mental Hyglene. If marked other than "natural", or items 23a or 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Mudical Examilities is notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of we life. DO NOT use retired)	orking	16b. Kind of Business/Industry
2121	filed within Hygiene. other than *	omp	Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATO		STEEL CAMPANI
land 2	be filed tal Hygie d other event. II	Be C		ame (First, Middle, M	Maiden Sumame)
ylaı	should be nd Mental marked o	To E	ALEXANDER M. ROSE SR. MAC	BEL LE	EE WYCHE
Maryl	d 2 sho th and 7 Is mu traum	X SI	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	Rural Route Number,	(0)
	ges 1 and t of Health if item 27 or other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory, or other place)	Date	Oc. Location - City or Town, State
e E	0 0 = =		1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) MT. ZION CEMETERN 11-	31-04 2	LANSDOWNE MARVIAND
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	BROW	NOR. FUNERAL HOME
	<u>7</u> 0 = € 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia		E., X3A-LTO, MD 2/2/7 Approximate
		5 17	shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a Ansequence of):	Tion	
	Examiner		Sequentially list conditions, b.		
	ted nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter underlying Cause (Disease or injury		
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68760,	eath certificate be executed attending physician and for use as the buriat-transit	edicai	d		
4	entifica ding pl		IF FEMALE: 23c. If yes, outcome of pregnancy		
Вох	attend I for us	cian	in the past 12 months?		23d. Date of delivery Month Day Year
P.O.	t the d by the tached	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown		
	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use an	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to the cause of death?
Records,	w require been signal	Completed		1 □ Ye	
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Vital	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical 26. Place of De	1 ☐ Yes 2	
of Vi	Physici this cer al direc	To B	examiner?		nce 6 Other (Specify)
o L	ding PI h. After th funeral		27. Manner of Death 1	28d. Describe ho	w injury occurred
Division	Attending or death. actor: After by the fune	ficat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, street, factory, office	28f. Location (Str	reet and Number or Rural Route Number,
Οį	s after s after al Dira	Certi	4 Homicide determined building, etc. (Specify)	City or Town	, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	29a. Certifier (Check only one) 1A Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place of the composition of the compositi	ce, and due to the ca curred at the time, da	use(s) and manner as stated. ate and place, and due to the cause(s)
	within 2 To the comple	Mec	29b. Signature and title of certifier 29c. License number	29	3d. Date signed (Month, Day, Year)
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		David cumbers no 199946		1/27/04
	11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	2 12 12
	Sta	10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Dalt.	/n // 1/1/8
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 9 2004 32. Registrar's Signature		

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			Registrar			Ce	rtificate	e or L	Jeath			Reg. No.	-004	1 06110
	Physicia	an.	Decedent's Name (First, Middle								Date of D Month	Day	Year	
	/Medic		Violet De	lores Rayı	nond						Januar			
	Examin		4a. Fecility Name (If not institution	n, give street and nur	nber)		4b. City,	Town, or	Location of	of Death		4c.	County of Dea	ath
			Greater Balt					son		0411		Ba	altimo:	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 15 F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B OCL. 7	irth ay,1 ^Y 64YC	9. Bi	inthplace (State or Foreign
	Director		215-32-6215 Usual Residence of Decedent		94	115.					,	, 1,00		. ,
	and w		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
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9	or ite	F	1 Never Married 2 Mar	Armed Fo	2 X No		1 ☐ Yes 2				rican, etc.)	1	Black, Wh	
<u>S</u>	rel', c	by	3 Widowed 4 □ Divorced	If Yes, Gir Year or D	ates:		TO THS A	₽ E□ 140	зреспу.				Specify:whi	rte
> 5-6	72 h	etec	15. Deceden (Specify only highe	it's Education st grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	d Occupa	ation during mos	it of work	ing	16b. Kir	nd of Business	s/Industry
<u> </u>	within 72 hours after than "naturs!", or ite to Me itcal Exantra	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5+)	iite.	Homem						Own Hon	ne
2 2	led w lygier her ti	ပိ	12 17. Father's Name (First, Middle,	(act)			пошеш	akei		arte Name	First, Middl			
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Z Z	12 st h an 7 ls r traur		Harry Raymond-			13701	Eck	Road	Hyd	es, l	Maryla:	nd 210	Town, State, 082	2.0 0000)
50.	1 and Healt em 2 ther		20a. Method of Disposition		20b.	Place of Disp	osition (Nan	ne of			Date	20c. Lo	cation - City o	r Town, State
$\mathcal{A}_{\mathcal{Q}}^{\mathcal{C}}$ Baltimore,	ages nt of nt of or o		1 Surial 2 Cremation	3 □Removal from	State Ga	cemetery, cre rdens o			e) 1	/24/	04			
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Ba	permit. Feges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturst", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examination matter most be notified at once.		21. Signature of distallation of	Marzar -										d 21206
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that of	aused the dea	ath. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory	arrest.	ar y ram	Approximate
	* - *		shock, or heart failure. List Immediate Cause (Final	only one carse on e	each line.	4								Interval Between Onest and Ceath
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õ	aath cer attendin for use	an/I	23b. Was decedent pregnant	23c. If yes, ou 1⊟Live t	tcome of pregr pirth 2 Te		□Ectopic pr	egnancy	,			2	3d. Date of de Month	elivery Day Year
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isic	death death ctor: / the	ical	3 Suicide 6 Could		of Injury - At	home, farm, si					28f. Location	(Street and	d Number or f	Rural Route Number,
Division of Vital Records, P.O.	P de c	Certification;	4 Homicide determ	build	ing, etc. (Spec	city)		,				own, State)		
-	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifyi	ng Physician: To the	e best of my kr	nowledge, dea	th occurred	at the tin	ne, date ar	nd place,	and due to th	e cause(s)	and manner a	as stated.
for	the Ho hin 24 h the Fu	Medical	(Check only 2 Medical one)	Examiner: On the b	easis of examin ner stated.	nation and/or in	nvestigation	, in my o	pinion, dea	ath occurr	ed at the time	e, date and	place, and du	ue to the cause(s)
	To th Withir To th	×	29b. Signature and title di certific	11/1/11		1110	-	_	e number	00				nth, Day, Year)
	1		> Wollen	mun	alle	W)		1)3	70	49	'		1-2	3-04 MD 21204
_	K		30. Name and address of perso	who completed cau	se of death (Ite	em 23a) (Type	, Print)		-	,				-
	•		RODNEY W	WILLIAMS	M.D.	4201	N.C.	IAR	LES S	57	Km 3:	213	ALTO.	MD 21204
	Sta	ate	31. Date filed (Month, Day, Year	32. F	Registrar's Sign		, de	1	والمع					
	Regist	rar		JAN 2 91	£004	AND WIND	1	17	-					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 22° 2004 DIANE 4:00 P.M ELIZABETH ROBERSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 2402 WELLBRIDGE DRIVE N/A5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Yrs. **Director** 214**-**68-5760 MAY 06 1957 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f ehow tra Medical Examiner must be notified at 10d. Inside City Limits N/A **BALTIMORE** 1√ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2402 WELLBRIDGE 21234 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 27 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it of Health and Mental Hygiene. If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) TEACHER BCPSCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be IRVIN ASHLEY DELORES TILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANLEY ROBERSON/HUSBAND 2402 WELLBRIDGE DR., BALTO., MD 21234 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
eny injury or oth P Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MT. PLEASANT U.M.C. 02/02/2004 POND TOWN, MD 21. Stonature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC asses a. 1701 LAURENS ST., BALTO., MD 21217 Rad1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-t Be Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 THNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 2 🗆 No 1 Yes 2 No 1 Tes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural 5 Pending Injury within 24 hours after death.
To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 321 Billy Myers Schendel MI 101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 9 2004

DHMH 17 Rev 1/2001

ORIGINAL

				State of Maryland					2001	02175
	Physicia	an	1 - State Registrar AMEND ITEM #4b I 1. Decedent's Name (First, Middle, Last) EDWARD DONAL	A		uncate or	Deatti	2. Date of Dear Month	th Day Year	3. Time of Death 925 PM
	/Medic Examin		4a. Facility Name (If not institution, give str ROCKFIELD M	eet and number) ANOR PARK		BEL A		1 2	4c. County of Deat	A D
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) June 1,	Year) 9. Bin 1926 Maj	thplace (State or Foreign buntry) cyland
	e Maryland 3e-f show fillwy at	Director	10a. State 10b. County Maryland Harford		Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3e or 24		10e. Street and Number 508 Linwood Ave.			10f. Zip Code 2101	4	1	0g. Citizen of What Co USA	untry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show eny injury or other treumatic event, the Medical Examinar must be muffiled at once.	by Funeral		. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	within 72 horiene. Then "nature in Medical E	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	ent's Usual Occup kind of work done to NOT use retired CUTIVE S	during most of wor ecretary	rking	16b. Kind of Business	,
and	ould be filed v Mental Hygie arked other I	Be	17. Father's Name (First, Middle, Last) Francis Sylvester		7			ne (First, Middle, I		
aryk	should and Mer s mark umatic	ဥ	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street			r, City or Town, State, 2	Zip Code)
altimore, M	ges 1 and 2 t of Health if item 27 I or other tre		Gary Reilly / Sor 20a. Method of Disposition 1 Burial 2 Scremation 3 Ref	20b. Pla		Landis C sition (Name of natory or other place		el Air, N	MD 21015 20c. Location - City or	Town, State
Baltim	permit. Pa Departmen Importent: eny injury once.		21. Signature of Funeral Service Licensee	Hill	22 1V		uneral H	ome, P.A.		
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Divisi	after dea Director	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre		LAKM GE		treet and Number or Ru	ural Route Number,
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	Sta	ite_	BERNARD J. YUK 31. Date filed (Month, Day, Year)	NA MD, DME 32. Registrar's Signatu		18 HOLA	NIKU MI	15 A	TIO MIG S	21222
	Regist		JAN 2 9 2004	A Comment		and a				

		1	For State Registrar	State of	Marylan		artment rtificate			and Me	ental Hyg	iene 19. No.	2001	1 0	2176
П			1. Decedent's Name (First, Middle,	Last)							2. Date of Deat _ Month		Year		e of Death
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>	Examin	_	4a. Facility Name (If not institution, g Manor Care	give street and num	ber)			Town, or OWSO	Location o n	of Death			ltimor		
H				. Sex	7. Age (In yrs. I	last birthday)	If Under	1 Year	If Under	24 Hrs. 8	B. Date of Birth				te or Foreign
	Funeral Director		213 18 0306	1 □ M 2 🔀 F	80	Yrs.	Months	Days	Hours	Min.	3. Date of Birth (Month, Day, 06/03/1	923	Ma	ryland	d
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or La	ocation							10d. Inside	e City Limits
	laryla shov	5	MD Balti	more		edale								1 🗆 ነ	es 2 No
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	ama a	ner	11. Marital Status	Armed For		.S. 13.	Was Deced If Yes, spec	lent of History of Cubar	spanic Ori n, Mexican	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	14	I. Race - Ame Black, Whit		1,
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3X Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	e -		1 ☐ Yes 2	X No	Specify:			s	pecify: Wh	ite	
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and	ould be filed within 72 hours after death with the Maryland Mental Hyglene. Mental Hyglene. arked other than "natural", or Itama 23a or 28a-f show arked other than "natural", or Itama attice or 20 to 10	Be c	Konstant Shein	131)							Turek		,		
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ore	Pages 1: nent of He ant: If iten ary or oth		20a. Method of Disposition **Description**: The Burial 2 Cremation : 2	B □Removal from	State	Place of Disposemetery, cre	matory or o	ther place		01/29			ation - City or .a1k,M		в
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	()		30. Name and address of person	who dompleted cau	se of death (Its	m 23a) (Type	e, Print)		1	OWS	m	11	d	217	204
1		ate	31. Date filed (Month, Day, Year)	3	egistrar's Sign	nature							-	<u></u>	
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920	be filed within 72 hours after death with the Maryland Hygiene. Hygiene de Hygiene de Chert than "neturel", or Items 23a or 28a-f show ide other than "neturel", or Items 23a or 28a-f show event, the Madral Examinar must be motified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 MNo If Yes, Give Year or Dates:	1	if Yes, specify Cubar	spanic Origin? (Specify Yes on Mexican, Puerto Rican, etc. Specify:	Specify: W	/hite, etc.
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2	be filed ntal Hygi od other event, i	To Be Co	17. Father's Name (First, Middle, Last) John T. Kelly		OTTE	e Manager	18. Mother's Name (First, Mi	iddle, Maiden Sumame)	TITCC
	. 1 and 2 should be Health and Mental tem 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (T) Mr. John Slade	(Son)	2872 1	Robin Road	nd Number or Rural Route N l, York, PEnns	sylvania 174	04
Baltimore,	Pages nent of ent: If i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	Removal from State	Oruid Ric	matory or other place dge Cemete	ery Jan. 29, 20 of Facilition By		le,Maryland
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f Vita	Physicien: this certificated ral director,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No	Hospital: 1 Inpatient	2 ☐ ER/Outpatie		4 El Hursing Home 3 El	Residence 6 Other (Specify)
Division o	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No	cribe how injury occurred	r Rural Route Number,
Divi	pitel or At ours after of erel Direct illed in by	i Certifi	4 ☐ Homicide determined	building, etc. (5	Specify)			or Town, State)	
×	the Hospitel thin 24 hours a the Funerel to mpletely filled	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	inar: On the basis of exa and manner stated	amination and/or in	nvestigation, in my op	pinion, death occurred at the	time, date and place, and 29d. Date signed (N	due to the cause(s)
	5 <u>3</u> 5 9		30. Name and address of person who	ompleted cause of death	ı (Item 23a) (Type), Print)	3974	Jahnery	horap Ishd
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Hurp:	Tal Kanda	il stown	mary Ishd
DI	IMH 17 Rev 1/	-	L JAN 2 9 2	2004	ORIGINA	AL.			

Physicia		Registrar 1. Decedent's Name (First, Middle, Las		12/04dhb <i>Cer</i>			2. Date of Death	ng. No.	3. Time of Deat
/Medic		Mary Emma Schis					January	25°, 2004°	1:30p.
Examin		4a. Facility Name (If not institution, give 7400 Dogwood Road	street and number)		4b. City, Town, o Windsor	Location of Deat Mill	n	4c. County of Dear Baltimo	
uneral irector		5. Social Security Number 6. Security Number 11 3 - 30 - 31 4 3 11 3 - 30 - 31 4 3 11 3 11 4	ex 7. Age □M 257 F 86	(In yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, March 20	9. Bin Co , 1917 M	thplece (State or Fore buntry) aryland
show		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Lim 1 ☐ Yes 2🛣
r 28a-f	recto	Maryland Baltimor 10e. Street and Number	ce	Windsor M	10f. Zip Code		10	Og. Citizen of What Co	ountry?
23a o	ai D	7400 Dogwood Road						Jnited Sta	
od other than "natural", or liems 23a or 28a-f show avent, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married \$\text{\text{\text{Widowed}}} \text{4 ☐ Divorced}	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo li	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 XNo	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
an "natura Medical E	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5-	+) (Give	tent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Business	
herth nt. tre		12 17. Father's Name (First, Middle, Last)	_	Adjust	tment Dep		ne (First, Middle, M	Montgomery	Wards Co
rked of	To Be	James Lee Hale					na Sador		on
E H		19a. Informant's Name/Relationship (7 Kenneth R. Schisle						City or Town, State, 2	
Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			natory or other plac			20c. Location - City or 4 Woodlawn	
Importa any inju once.		21. Signature of Funeral Service Licen	1500					rs Funeral town, MD 2	
sician ledical	3	23a Cent 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	θ.	er the mode of dyir	g, such as cardia	or respiratory arre	ost,	Approximate Interval Between Onset and Death
physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):					
hy.			23c. If yes, outcome			,		23d. Date of de	
attending for use as	Ф	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	livery Day Year
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			1 - For Stete Registrar	State of Marylan		artmen rtificat			nd M		Reg. No.	200) 4 (121	8
	Physici /Medic		1. Decedent's Name (First, Middle, Las Charles Cu	rtis Stulck						2. Date of Dea Month January		200°	ar	Time of Dea	th M
è	Examir		4a. Facility Name (If not institution, giv. 6605 Sweet Air				Town, or esvi	Location of 11e	Death			County of D Carro			
	Funeral Director		5. Social Security Number 6. S 407-01-5526	ex 7. Age (In yrs. S2 82	last birthday) Yrs.	If Under Months		If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Day July 1	h y, <i>Year)</i> 192	9. 1 K	Birthplace (Country) Y	State or Fo	reign
	e Maryland ta-f show	ctor	10a. State 10b. County Md Carroll		y,TownorLo									side City Li	
	h with th	ai Dire	10e. Street and Number 6605 Sweet Air La	ne		10f. Zip						en of What USA	Country?		
980	be filed within 72 hours after death with the Maryland ital Hygiene. do other than "natural", or items 23e or 28e-f show event, the Mexical Exacting must have be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Types 2 No WW- If Yes, Give Year or Dates:	.S. 13.	Was Deced If Yes, spec	**	spanic Origi n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		4. Race - A Black, W Specify: W	/hite, etc.	dian,	
21215-0036	d within 72 ho giene. Ir then "natur Ins Medical.	Completed by	15. Decedent's Et (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	life.	dent's Usua kind of wo DO NOT us ervic	rk done d se retired,	urina most	of workir	- 1		nd of Busine	_		
Maryland 3	should be filed withir nd Mental Hygiene. I marked other than umatic event, tra Mi	To Be C	17. Father's Name (First, Middle, Last) Walter S. Stulch							(First, Middle, na Lawr					
			19a. Informant's Name/Relationship (Chloe (Polly) E. S	Stulck (spouse)	6605	Swee	t Ai	r Ln.		Route Numbe)	
Baltimore,	Page ent o ht: If y or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☑ Other (Specify	Removal from State (20b. Portion Duck)	Place of Dispo cometery, crer laney	sition (Name natory or o	ne of ther place y Ma	us. 1-		ate 04		nium,		tate	
Balt	permit. F Departm Importar any injur		21. Signature of Funeral Service Licer Paige Haight	Herbert	22	2. Name an	id Addres	s of Facility	Hai	ght Fun ille, M	eral ld 21	Home 784	& Cha	ape1	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. Due to (or as a conseq	Ca wence of):	er the mod		g, such as c	ardiac o	r respiratory ar	rest,		Inten	oximate val Between et and Death	
8760,	ate be executed hysicien and the burial-transit	Ilcai Examiner	Sequentially list conditions, if any leading in immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence o											
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rds, P.	w requires that been signed t should be det	by	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	_	se contribute	e to the cau Probably		
I Records,		Completed	<u> </u>						_	24a. Was a autop perfor	sy	24b. Were prior death		on of cause	able of
Vital	Physician: The this certificate har all director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatien	at 3 DC	Othe			(Check only on		□Other (S	(pecify)		
ion of	ding h. After fune	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury Work			8d. Describe h			, , , ,		
Division	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory	, office		2	8f. Location (S City or Tow		Number or	Rural Rout	e Number,	
	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by	Medical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	h occurred vestigation,	at the tim , in my op	e, date and pinion, death	place, a occurre	nd due to the o	ause(s) a fate and	and manner place, and o	as stated. due to the ca	ause(s)	
	To the within To the Complex	Me	29b. Signature and title of Certifier	MD			D 3	number 4849		-		signed (Mo			
	5		30. Name and address of person who		23a) (Type,	Print)	Road	d F	Ide	rsburg				-	
	Sta Regist		31. Date filed (Month, Danyea)	2004 32. Registrar's Signa	iture	foods	9			()					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #25 PER ME G827 1/29/0/CENtificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0230 M Schweitzer nristian /Medical 4c. County of Death 4b. City, Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center Baltimore C. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1**X** M 2□ F 72 WASHINGTON, DC 577-46-5819 21. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ral', or Iteme 23a or 28a-f show Examiner must be notified at 1 Yes XXNo Director BERKELEY MARTINSBURG W٧ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 25401 USA 98 KENT COURT Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ent: if item 27 is marked other than "natural", or liter any or other traumatic event, tra Medical Examinatiny or other traumatic event, tra Medical Examination 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify WHITE þ 3 Widowed 4XXDivorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) TELEPHONE CO. & P Elementary/Secondary (0-12) College (1-4or 5+) MANAGEMENT 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit Pages 1 and 2 should be fi Department of Health and Mental I Importent: If item 27 is marked of any injury or other traumatic even once. NELLIE SLYE CHRISTIAN FREDERICK SCHWEITZER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5059 OLD BATHOLOWS RD., MT. AIRY, MD 21771 PAUL SCHWEITZER 20b. Place of Disposition (Name of JANUARY 20c. Location - City or Town, State 20a. Method of Disposition ROCK CREEK CEMETERY WASHINGTON, DC 1

Burial 2 □ Cremation 3 □ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) 30, 2004 21. Signature of Funeral Service Licensee BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., Ì Buren MARTINSBURG, WV 25402 Spelson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) subarchnold **Physician** /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY (VIII) EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner 10 min accident The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Eetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No Completed has been libi demik 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: XX Yes 1 Inpetient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 □Natural 5 Pending 03 1 ☐ Yes 2 X No 30 119 at tune death. investigation 30 PM Accident Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 4732 nome Baltimae within 24 hours a To the Funeral (1 Decitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12004

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 2 9 2004

00 University 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maylong

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25,2004^{ear} JÄNÜARY **Physician** BERNARD SANDLER 5:40 A M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 19, 1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 M 2 □ F 74 218-28-5262 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Itams 23a or 28a-1 show the Medical Examiner count by notified at 1 Yes 2 No Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21208 3800 OLD COURT ROAD #229 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or flar any injury or other traumatic avent, the Meulcal Examination. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify by 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2^{College (1-4or 5+)} Elementary/Secondary (0-12) COMPUTER & CAMERA REPAIR TECHNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERTHA MERMELSTEIN SANDLER REUBEN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9609 MIDDLERIDGE COURT - BRANDYWINE, MD 20613 NACHELLE KARL / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) (ANSHE EMUNAH) AITZ CHAIM 1/26/2004 BALTIMORE, MD 21. Signa ure of Funeral S rvice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 newson Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** S. juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit to the Hospital or Attending Physicia ... The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Many r of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) nd title of certifier 29b. Signature 047704 dress of person who completed cause of death (Item 23a) (Type, Print) oo old court rol. 30. Name and a PHAM 12 B 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

		ı	1 - For State Registrar	State of Maryla	-	artment of F rtificate of			ene 2004	02185
	Physici /Medic		1. Decedent's Name (First, Middle, Last) $I \perp I A$			SEGEL		2. Date of Death Month JANUARY	Day Year 26, 2004	3. Time of Death 2:25 P M
) -	Examin		4a. Fecility Name (If not institution, give st JEWISH CONVALESCE 5. Social Security Number 6. Sex	NT CENTER	s. last birthday)	4b. City, Town, o BALTIM If Under 1 Year		8. Date of Birth	4c. County of Deeth	
	Funeral Director			W 005)4 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) SEPT. I1	,1909 Cou	place (State or Foreign ntry) BELARUS
	show	'n	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the M or 28s-f	Director	MD BALTI 10e. Street and Number	MUKE	BAL	TIMORE 10f. Zip Code		100	g. Citizen of What Cou	
	s 23a c	erai D	7920 SCOTTS LEVEL		11.6	N. D. de de de de	21208		14 Page America	U.S.A.
920	hours after death with the Maryland tural', or Items 23a or 28s-f show al Examiner must be notified at	by Funerai	11. Marrial Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 7 Year or Dates:	'	was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specity:	Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-003	ithin 72 ie. ien "na	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use retired	durina most of worki	ng	Bb. Kind of Business/In	
	I be filed wintal Hygier ed other the	Be	17. Father's Name (First, Middle, Last) MATUS		SEGI		18. Mother's Name		iden Sumame)	
Maryland	should be and Mental is marked o	ဥ	19a. Informant's Name/Relationship (Typ	e, Print)			REBECA and Number or Rura	l Route Number, (City or Town, State, Zip	NKNOWN)
	1 and 2 Health a tem 27 li		ELIZAVETA SEGEL /	WIFE 20b.		SCOTTS sition (Name of			IMORE, MD	
altimore,	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, cren	natory or other plac			REISTERSTO	
Balt	permit. Pages 1 an Department of Heat Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licenses		22	. Name and Addres	ss of Facility SO	L LEVINS	ON & BROS. IKESVILLE,	, INC.
	Physician /Medical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ARDUA	er the mode of dyin	g, such as cardiac o	r respiratory arres	/mms	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions, if any, leading to immediate	Jue to (Jas a cons	87					
	ecuted and transit	Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
8760,	ficate be executed physician and s the burial-transit	dical E	d.		rquerice ory.					
O. Box 6	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
rds, P.	The law requires that the the bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions cont	ributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to the	he cause of death?
I Records,		Completed						24a. Was an autopsy performe	prior to cor	psy findings available impletion of cause of
Vital	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho	ospital: 1 Inpatient 2[☐ ER/Outpatien	Oth	26. Place of Death	-300400-500	- Totale	
ion of	fing Ph J. After th funeral	\vdash	27. Manny of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	y at 2	ne 5 Hesideno 28d. Describe how	be 6 Other (Specify injury occurred	0
Division	sal or Attenders after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre home, farm, stre	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai (29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examine	cian: To the best of my kr er: On the basis of examination manner stated.	nowledge, death nation and/or inv	occurred at the time vestigation, in my of	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier		44.0	29c. License	e number	29d	. Date signed (Month,	Day, Year)
	\		30. Name and a ress of pe on who com	pleted cause of death (Ite	23a) (Type,	Print)	(Y 40		DW, 26	, 2004
			31. Date filed (Month, Day, Year)	32, Registrar's Sign	62	10 11	cus 1/	ue, 131	my wil	21215-
	Sta Registr	100	IAN 2 9 2004	file con	15 Am	ME		3f.		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** JAMMARY 2004 Major E. Surrette, Ja.

4a. Facility Name, (If not institution, give street and number)

Center 06:30 MM /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 10M 20 F 217-38-1580 Director June 13,1942 MD Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore County lowson MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a elvose Avenup 21212 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 Tho If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Warried Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Black Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 Is marked other then? Elementary/Secondary (0-12) College (1-4or 5+) Mechnix 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Major E. Survette. Willie Map Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Surrette Idaughter 1527 Rosewick Avenue Baltimone MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 1/24/04 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimone 22. Name and Address of Facility
Have P Crose Funeral
709 Tessier St. 21. Signature of Funeral Septice Licensee 10515 Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACQUIRED IMMUNE DEFICIENCY DISEASE **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐Ectopic pregnancy Month Day Vear 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. RENAL FAILURE 2 NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Director: After Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 | Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mella DØØ4141Ø 2014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 M. D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 9 2004 Registrar

		For State Registrar			Ce	rtificate d	of Dear	th		Reg. N	. 200	
Physicia	ın	1. Decedent's Name (First, Middle Julian	Earnes	t Tho	mas				2. Date of D		10, 200	3. Time of D 1304P
/Medica Examine		4a. Facility Name (If not institution	give street and nu	ımber)		4b. City, Tow	vn, or Location	on of Death		4	c. County of De	eeth
Zadillio		Southern Mary				Clinto					Prince	Georges
Funeral		5. Social Security Number UNK	6. Sex 100 M 2 □ F	7. Age (In yrs. I	last birthday, &Y Yrs.	If Under 1 Y Months Da		der 24 Hrs. rs Min.	8. Date of B	irth au Year	^{9. E}	Birthplace (State or Country) Wash
Director		Usual Residence of Decedent										
within 72 nous atter death with the maryland than "natural", or items 23e or 28e-f show the Miscle Examiner mat be notified at	_	MD 10b. County			y, Town or L Tamp 1	ocation .e Hill	10					10d. Inside City
28a-f	Director	10e, Street and Number	•		Temp1	10f. Zip Co				10g. C	itizen of What	1
3a or	0	5310 Stratfo	rd Lane				20748				S.A.	,
ems 2	Funeral	11. Marital Status		edent Ever in U.	S. 13.	Was Decedent If Yes, specify			ecify Yes or N Rican, etc.)			merican Indian, hite, etc.
F, or lt	by Fu	1 X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced		2⊈No ive		1 □ Yes 2 1□					Specify: B	
ical E	ted	15. Decedent	's Education		16a. Dece	dent's Usual O	ccupation	nace of work	rina	16b. I	Kind of Busines	
Department of health and Mential rivgiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic svent, the Mudical Examiner must be notified at once.	Completed	(Specify only highes		(1-4or 5+)		kind of work d DO NOT use re N/A	etired)	TOSE OF WORK	ang		N/A	
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narke natic	၉	Earnest R. 19a. Informant's Name/Relationsh		Jr.	10h Mail	ing Address (St			l Y. W			7in Cadal
27 Is n traur		Cheryl Y. Tho		ther								, MD 207
Item	-1	20a. Method of Disposition		20b. P	lace of Disp	osition (Name o	of r place)	1	Date	20c. l	Location - City	or Town, State
ant: If ury or		f Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		Li1		matory or other Cemet	•	1				tland, M
Import any inj once.		21. Signature of Funeral Service I	icensee		2	2. Name and A	ddress of Fa	icility Aus	stin R	loys	ter Fu	ıneral H
= 4 0		23a. Part1. Enter In Se, or	complications that	sed the death		821 14					sh,DC	20011 Approximate
		23a. Part1. Enter the se, or shock, or art failure. List Immediate cause (Final	only one cause on	each line.								
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DHMH 17 Rev 1/2001

ORIGINAL

			i lease i	State of Maryla				nd Mental H	_	DIC.	
			1 - For State Registrar	State of Maryla		tificate of		ia ivicinai i i	Reg. No.	I U L	02189
			Decedent's Name (First, Middle, Last)	,				2. Date of D	eath		3. Time of Death
	Physici		Nathaniel	Tiles				Janua	Day	2000	1515 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of D		4c. County	of Death	
			Stady Grove P	adventist	HOSON	u ko		ic	1110	Uto	omery
	Funeral		5. Social Security Number 6. Security Number 1K	x 7. Age (<i>In yr</i> DM 2□F 55	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of B. (Month, D. Oct.)	irth Pay, Year)	Cour	place (State or Foreign htry)
- 12	Director		Usual Residence of Decedent	33	113.			OCL.	10, 1948	we	st Virginia
	yland now		10a. State 10b. County	10c. (City, Town or Loc	ation				1	10d. Inside City Limits
	B-f st	ctor	MD Montgom	ery	Montgome	ery Villa	age				1 Yes 2 No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of		-
	ath w	Funeral Director	19301 Watkins Mil				886		United		
	ltems per de	rue	11, Marital Status UNK 1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13. W	/as Decedent of F Yes, specify Cuba	lispanic Origin an, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	O- 14. Had Bla	ce - Americ ck, White,	
39	urs afi	þ	3 Widowed 4 Divorced	1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	1	□Yes 27∏ No	Specify:		Specif		ican rican
Š	ilied within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28e-f show yth, the Medical Exartinat must be rodified at	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	ent's Usual Occup kind of work done O NOT use retired	pation	f working	16b. Kind of B	usiness/In	dustry
2	ithin Per Mes	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired known	d)			1	
Maryland 21215-0036	lled w lygier her ti	S	11. 17. Father's Name (First, Middle, Last)		uı	IKIIOWII	19 Mother's	Name (First, Middle		nknow	n
anc	t be find the Be	Harold Tyler					ette Clar		10)		
2	should Ind Men	ဥ	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailing	Address (Street		or Rural Route Numi		State, Zic	Code)
	and 2 : ealth ar n 27 is	1	Kim Viti Fiorentin	Guardian o	f 11921	Rockvi	ille Pi	.ke, Rockv	ille. MI	20	852
Jre,	of Hei		20a. Method of Disposition	20b		ition (Name of atory or other place		22/04	20c. Location		
Baltimore,	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examination and DOCs.		1 □ Burial 2X X Cremation 3 □ P '4 □ Donation 5 □ Other (Specify)	temoval from State		Cremato	1 - 1		Baltimo	re, l	MD
alt	Departr Departr Importa any inji		21. Signature of Funeral Pervice Ligens	00 10 11 a no	225	Name and Addre	ss of Facility	Funeral a	nd Crema	tion	Center
_	ZOE = 3		Jule 17	100001		O40 KOCK	corre	rike, Koc	kville,	MD :	20852
ę		-	23a. Part I. Enter the disease, or compleshock, or heart failure. List only or	re cause on each line.	eath. Do not ente	r the mode of dyin	ng, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	175 pi	ratio	V KL	1601	WONIG	7		
	Examiner		f	Due to (or as a cons	'	Drige	tary	101	\ C 1. x0		
3		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		20119	1	4 41	, - , C		
	cuted od ransit	Examiner	that initiated events	:	to pc	719					
760,	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a conse		Frank	,				
876	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	dical		1 1+26.	PHYS	Crew	11 0				
Box 68	ding g	/Me	IF FEMALE:	3c. If yes, outcome of preg	inancy				22d Da	ite of delive	
Bo	atten f for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3 🗌	Ectopic pregnancy Other (specify)	/			onth	Day Year
P.O.	tithe c by the achec	hysi	9 Unknown	9□ Unknown							
a,	res tha signed I be det	Completed by Physician/Med	Part II. Other significant conditions con			derlying cause giv	en in Part I.	23e. Did	tobacco use con	nbute to th	ne cause of death?
ğ	w require been sig should t	led	Didpelen	Welli	ピック			1_	Yes 2 0	3 Prob	oably 4 □Unknown
ecc	law ras be	ple	Cerepera	rasi-la.	v a	colde	nf	24a. Was	psy	prior to cor	psy findings available impletion of cause of
<u>ح</u>	cate h	Con						perf		death? 1 🗌 Yes	2 No
Vits	ician certifi rector	Be	25. Was case referred to medical examiner?	fospital:		3□ DOA Oth	ar	Death (Check only			
ŏ	Phys r this ral di	: To	1 Yes 2 No	28a. Date of Injury	☐ ER/Outpatient 28b, Time of	3□ DOA 28c. Injur Wor	4 🗆 IAGISII	ng Home 5 ☐ Res 28d. Describe	how injury occur		y)
ion	nding th: :: Afte	atlor	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury		k? Yes 2 □ No				
Division of Vital Records,	er dear	Certification; To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, office			(Street and Numb	er or Rura	I Route Number,
Ö	ital or rs afte al Dii led in	Cer		Daniella, did. (ope							<u> </u>
	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Exami:	sician: To the best of my k ner: On the basis of exami	nowledge, death nation and/or inv	occurred at the tirestigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time	cause(s) and ma , date and place,	anner as st and due to	tated. o the cause(s)
	thin 2 thin 2 the omplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
}	FRES		Minu Gant	•		-	1116	,	70 10	0	(220cy
	2		30. Name and address of person who co	empleted cause of death (It	tem 23a) (Type. F		11101		2000	(4.7)	122019
	Ű		V Gantimo	19829	Docto	DYI	١٠ (26 1 man	toun 1	dr.	20874
Ę	Sta		31. Date filed (Month, Day, Year) JAN 2 9	32. Registar's Sig	nature	A					
	Registi	(ell	OUIT A A	-UUT FREEHOLD	Es All	A TOTAL STATE OF THE STATE OF T					

			1 - For State Registrar	State of Mary	land / Departm <i>Certific</i>	ent of Health and ate of Death		ene2001	02190
			1. Decedent's Name (First, Middle, Last)			,	2. Date of Death		3. Time of Death
	Physici /Medio		Dorothy	TRUE	here 7	_	Month JANUMA	Day Year	L CAN
	Examir		4a. Fecility Name (If not institution, give s	street and number)	4b. 0	City, Town, or Location of Dea		4d. County of Dea	
			MILLENNIUM NU	IRSING HO	OME	BAITI	MORF	/	ULA
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. [ast birthday] If U	nder 1 Year If Under 24 Hi		g. Bid	thplace (State or Foreign
	Director		217-20-3422 15	M 200 F	SO Yrs. Mon	hs Days Hours Mi	OCT.	1923 M	ARILL AAIN
	P .		Usuel Residence of Decedent						7-100
	how	L	10a. State 10b. County	100	c. City, Town or Location	2	a		10d. Inside City Limits
	a Ma	Director	MARYLAND N	/A	1	ALTIMOI	RE GII		1 ⊠Yes 2 □ No
	라 다 or 28	l'e	10e. Street and Number		10f	Zip Code	10	g. Citizen of What C	ountry?
	th wi	al	1217 W. FA	HETTE S	STREET	212	23	115	4.
	dea	Funeral	11. Marital Status	2. Was Decedent Ever Anned Forces?		ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Am	
ထ္	or its	Ŀ	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No			mo mean, etc.)	Black, Whi	te, etc.
8	ours	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		s 2,12 No Specify:		Specify:	LACK
ည်	72 h natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's l	Isual Occupation work done during most of w	orkina 1	6b. Kind of Business	/Industry
7	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)			
7	ygier ygier t.	Ç	12 TH GRADE		1100	SEKEEPE	ER	SELF-E	MPLOYED
밀	be filed within 72 hours after death with the Maryland Hygiene. I have the Ynderel Exert for munt to motified a avent, the Medical Exert for munt to motified a	Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle, Mi	aiden Sumame)	/
Maryland 21215-0036	should nd Men marke	ဥ	CARROLL	<	STEWAR.	r DAL	DIE	ST8	-WART
ä	C 48 70 10		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailing Add	ress (Street and Number or F	Rural Route Number,	City or Town, State,	Zip Code)
_	1 and Health em 27		DORCTHY TRUEHE		ER) 2540	W. LomBr	RD ST.UN	ITP BALTO	D. Mb. 21223
Baltimore,	of H of H filer roth		20a. Method of Disposition 1. Burial 2 Cremation 3 Re	20	Ob. Place of Disposition cemetery, crematory	Name of or other place)	Date 20	c. Location - City or	Town, State
Ĕ	Pages nent of int: If it		'4 □ Donation 5 □ Other (Specify)	smovar nom State	MT. ZION	- A - 1	28-04	ANSMU	MENA
a	permit. Pag Department Important: any injury c	Π	21. Signature of Funeral Service License			and Address of Pacifity	Benual I	R. FUNE	RAL HOME
m	80 5 8 8		Lunch !	V- Wille	200 191	ASTATE ELLE	DA AVE	BAITO	40. 21217
a.e.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the	death. Do not enter the	node of dying, such as cardia	ac or respiratory arres	t,	Approximate
	Physician		Immediate Cause (Final	e cause on each line.	1001.1	8 11	. L:)		Interval Between Onset and Death
	/Medical	-	disease or condition resulting in death)	Due to (or as a cor	nsequence of):	INFINE	7/00		
78% 3A	Examiner				,				
	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	isequence of).				
	uted d ansit	直	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
o,	exector and in an ital-tr	Examiner	resulting in death) Last	Due to (or as a cor	nsequence of):				
8760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical							
8	ificat g phy as th	ed							
ŏ	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 23	lc. If yes, outcome of pr				23d. Date of del	iverv
ň	d for	cla	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ . 4 ☐ Pregnant at time		c pregnancy (specify)		Month	Day Year
0	at the de by the a tached	hys	9 Unknown	9□ Unknown					
J.	res that igned to be deti	by P	Part II. Other significant conditions con	ributing to death but not	t resulting in the underlying	g cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
S	puire;						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
Hecords,	w requ	Completed					24a. Was an	24b Wess of	tangu findinga qualahla
9	9 = 9	E .					autopsy performe	prior to	stopsy findings available completion of cause of
_	ician: The certificate rector, pag		20 11				1 ☐ Yes 24	No 1 ☐ Yes	2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:		Cther -	ath (Check only one)		
<u></u>	Phys this ral dir	-	1 Yes 2 No	1 ∐ Inpatient 28a. Date of Injury	2 ER/Outpatient 3	DUA 4 Tursing	Home 5 Residence		cify)
S C	ding F th. After funera	를 I	1 ☑ Natural 5 ☐ Pending	(Month, Day Yea	nr) Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
DIVISION	lal or Attending s after death. al Director: After ad in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e Place of Injuny	At home, farm, street, fac		29f Location (Ctra	A and Montage B	
5	- a.e.	Ē	4 Homicide determined	building, etc. (Sp	pecify)	tory, ornes	City or Town	et and Number or Ru State)	irai Houte Number,
_	Hospital 24 hours 2 Funeral tely filled		29a. Certifier 1 Certifying Physi	cione To the best of my	Incompany of the second				
V	Hos 24 hc Fun Fun stely	edical	(Check only 2 Medical Examin	er: On the basis of exar and manner stated.	nination and/or investigat	ed at the time, date and plaction, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospital of within 24 hours aff To the Funeral Discompletely filled in	Mec	29b. Signature and title of certifier	and manner stated.		29c. License number	204	. Date signed (Montl	Day Year
1	To To		10000						
	ì.	-	VX Yale	~ Ue	MINS	DO0299 IverSp.	40 VI	TNUAR	7 1 1004
	M		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type, Print)	1	1 -1 2	1 . 1	2 00 - 0
4.			31. Date filed (Month, Day, Year)	22. Registrar's S	ionature	werds.	81018	Ma.	LOYOS
1000	Sta	6		Jan. Hoylatiai 5 3	1. 6 .6		V		

	1	State Registrar AMEND ITEM #5 PER FH G8	27 1/29/0/ Ge	artment of Health ar <i>rtificate of Death</i>		Reg. No.	2004	0219
		. Decedent's Name (First, Middle, Last)	21 1/22/04 311		2. Date of D	eath Day	Year	3. Time of Death
Physicia: /Medica	_	ELIZABETH -	TAYLOR		01	28	2004	12 6
Examine		a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Location of I	Death		County of Death	
		YIHR C - 3000 HOR					DIMAR	
Funeral		Proj/Sepgity/1408gr 6. Sex	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of B	ay. Year)		place (State or Fore ntry)
Director	T	Isual Residence of Decedent	91		111011	1917	< Md	
Wo H		0a. State 10b. County	10c. City, Town or Lo			0.6		Od. Inside City Lim
Bell	ķ	MD HOWARD	ELLICOTT C	ITY , 3004 MG	ORTH RID	ue R	D	1 □ Yes 2√□1
or 28,	ě	0e. Street and Number		10f. Zip Code			en of What Cour	ntry?
238	ä	3004 MORTH RIDGS		21043			SA	
f Health and Mental Hygiene. item 27 is marked other then "netural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinat must be notified all	Funeral Director	Armed Ford		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	lo- 1	 Race - Americ Black, White, 	
P 를	by Fr	1 Never Married 2 Married 1 Yes 3 If Yes, Give 3 Widowed 4 Divorced Year or Da	A	1 ☐ Yes 2 ☑ No Specify:			Specify:	ucacia
le Ma	g g	3 ☑Widowed 4 ☐ Divorced Year or Da 15. Decedent's Education		dent's Usual Occupation		16h Kin	d of Business/In	
ed :	Completed	(Specify only highest grade completed)	(Give	kind of work done during most o DO NOT use retired)	f working		rical	adsity
then.	E C	Elementary/Secondary (0-12) College (1-11	4or 5+)	ecretary		CIE	iicai	
Hyg ent, I		7. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle	e, Maiden S	Sumame)	
Mental narked	To Be	William Salchunas		The	resa Duba	ck		
and Mental Hygiene. is marked other then aumatic event, I'la Ms		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number				
alth a	1	Clifford W. Taylor (son)	1390	Henryton Rd.,	Marriotts	ville	, Md 211	104
of Health fitem 27 i r other tra		Oa. Method of Disposition	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date	20c. Loc	ation - City or To	own, State
int of it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	late	on Cemetery 1-	31-04	West	minster,	, Md
Department of Importent: If it any injury or conce.		21. Signature of Funeral Service Licensee Para Sargut Service	t P	2. Name and Address of Facility O. Box 195 Syk	Haight Fu esville.	neral Md 21	Home & 784	Chape1
nysician and he burial-transit	licai Examiner	f any, leading to immediate auss. Enter Underlying Cause (Disease or injury hat initiated events c.	or as a consequence of): or as a consequence of): or as a consequence of):	eben Varula Ebullatein	V Accid	Ceri		
ing pl	Med	F FEMALE:						71
ed by the attending ph detached for use as th	Physician/Mec	23b. Was decedent pregnant 1☐Live bit	int at time of death 5	□Ectopic pregnancy □ Other (specify)		2.	3d. Date of delive Month	ory Day Year
ුල් දී .	<u>S</u>	Part II. Other significant conditions contributing to de-	ath but not resulting in the u	underlying cause given in Part I.	1	tobacco us		he cause of death?
een sign	Completed				_	1103 2	7140 0 0 1 1 1 0 1	abiy a Bonane
has b	od l					opsy	prior to co	psy findings availa mpletion of cause
page	ပ်				1 ☐ Yes	formed? 2 No	death? 1 🗌 Yes	2 No
ector, pag	Be	25. Was case referred to medical examiner? Hospital:			f Death (Check only			
sidi e	٥	TUTES ZUMO	patient 2 EP/Outpatient Finjury 28b. Time of		ing Home 5 Res			y)
th. : After this certifica • funeral director, p	o	27. Manner of Death 28a. Date o (Month	n, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		s now ununy	occurred	
r death. actor: Afte by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	of Injury - At home, farm, st			(Street and	Number or Bura	al Route Number,
Direction by	Certification;	4 Homicide determined 256. Flace buildin	g, etc. (Specify)	root, raciory, onico		own, State)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
within 24 hours after death To the Funeral Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying Physician: To the 2 Medical Examiner: On the ba	sis of examination and/or in					
the the mplet	Med	one) and mann	er stated.	29c. License number		20d Date	signed (Month,	Day Yearl
To To		29b. Signature and title of certifier		D30641		Jan		9 2004
0		30. Name and address of person who completed cause	of death (Item 23a) (Type,	, Print)	0 11		-	1 5 1
~		Ramesh Sabapahi	3400 Erdu	an Mienue	Baltu	resp	nayou	1 9141)
		Mannes M Sterrage	2 for Char	0001	10 0 1 3 0 1			

ORIGINAL

			State of Man	yland / Depa	artment of Hea tificate of De	alth and Mo	ental Hyg	iene	04 02192
	Physici /Medio		1. Decedent's Name (First, Middle, Last) EDWARD TOME				2. Date of Deat Month O 1	Day 16 2	Year 3:05P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Cen		4b. City, Town, or Loc Be1	Air		4c. County	ord
	Funeral Director		217–50–2944 ¹ X ^M ² □ ^F 5	In yrs. last birthday) 5 Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth	48	9. Birthplace (State or Foreign Country) Maryland
	f ahow	or	Usuel Residence of Decedent	Oc. City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland oms 23a or 28a-f ahow Frutst be radiffed at	Director	10e. Street and Number 3624 Scarboro Road		10f. Zip Code 21154		1	0g. Citizen of W	fhat Country?
705	iurs after death with the Marylan al', or items 23a or 28a-f ahow Exancing the coefficed at	by Funeral	11. Marital Status 11 Narital Status 12 Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	i i	Vas Decedent of Hispa Yes, specify Cuban, N	nic Origin? (Spe Mexican, Puerto F pecify:	cify Yes or No- Rican, etc.)	Black	- American Indian, k, White, etc. White
/215-00	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		lent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of workin	g	16b. Kind of Bu	
17 17 17 17 17 17 18 19 19 19 19 19 19 19	be filed tal Hygie d other event.	To Be Cor	8 17. Father's Name (First, Middle, Last) Christopher D. Tome	Fa		Mother's Name		Agricu Maiden Sumam	
/04 Mary	nd 2 should lith and Men 27 ia marke r traumatic		19a. Informant's Name/Relationship (Type, Print) Christopher Tome/Brother		g Address (Street and ulaski Highwa			, City or Town, . 1009	State, Zip Code)
$I/I_{\mathcal{C}}$ Baltimore,	Pages 1 a ent of Hes nt: If itam ry or othe	li	20a. Method of Disposition 12 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemptery, crem Shenberge	sition (Name of natory or other place) ers Chapel	1/20/		20c. Location - C	City or Town, State
/ Balti	permit. Departm Importe any inju		21. Sinature of Funeral Service Licenses	lel 1	. Name and Address of	Facility Ha	kejes	fine.	af Home
	Physician		231. Part . Forer the disease or complications that caused the shock, or heart failure. List only one cause on each line.		er the mode of dying, so			est,	Approximate Interval Between Onset and Death
AL	/Medical Examiner		disease or condition resulting in death) Due to (or as a condition at the condition of the condition at the condition of the condition of the condition at the condition of the		the care	Tragore	4 (621		10 years.
38973 68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cond						
1 R# 13	The law requires that the death certifical ate has been signed by the attending phropage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at time 10 □ Unknown	☐Fetal death 3☐	Ectopic pregnancy Other (specify)			23d. Date Mor	o of delivery th Day Year
Ms, P.	uires that signed by	d by Ph	Part II. Other significant conditions contributing to death but r	not resulting in the un	nderlying cause given in	n Part I.	23e. Did tot	1	bute to the cause of death?
na ra	hyaician; The law req this certificate has beer al director, page 2 shou	Complete					24a. Was a autops perforc	p new? d	/ere autopsy findings available rior to completion of cause of eath?
duce	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes	2010Outpatient	Othor	i. Place of Death			r (Specify)
ion of	ling F		27. Manner of eath 1 Natural 5 Pending (Month, Day Y) 2 Accident investigation	(ear) 28b. Time of Injury	28c. Injury at Work?		8d. Describe ho		
M≪ Divisi	ei or Atta s after des ai Diracto	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	eet, factory, office	2	8f. Location <i>(St.</i> <i>City or Towr</i>		or or Rural Route Number,
10	To the Hospitel or Attanding Phyaician: The la within 24 hours after death. To tha Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of real manner states Medical Examiner: On the basis of examiner and manner states	kamination and/or inv	estigation, in my opinio	on, death occurre	nd due to the ca d at the time, da	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
•	To the within To the comp	Σ	29b. Signature and title of certifier M.)	29c. License nu	2167	72 5	9d. Date signed	(Month, Day, Year)
			30. Name and address of person who completed cause of deal	th (Item 23a) (Type, I DPPC	Print) Clesar	pee.bi	Dr.	BRA	ar, MD
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 2 9 2004 Registrates	Signature	Jakes .				

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			, ror	epartment of Health and M		2001	00100
			Registrar	Certificate of Death		. No. 2004	02193
	Distance of the second		1. Decedent's Name (First, Middle, Last)		2. Date of DeathMonth	Day Year	3. Time of Death
	Physicia /Medic		HENRY B. TRABERT.	-	JAN 2	1 40 61	835AM
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth	1
			GOOD SAMARATAN HOSPITAL	BALTIMOR	E	NA	
- 10 m	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birts	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		iplace (State or Foreign intry)
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1	9		Usuel Residence of Decedent				
	ylar how		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
2	B-1-8	toi	MD BOLTINDRE PAR	Kulle			1 ☐ Yes 2 € No
	r 28	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cou	intry?
	ous after deam with the maryland ref', or Itama 23e or 28e-1 show Exeminer must be maillied at	alD	7609 Old HARFORD Rd	21234		W5 1	
	ma dear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Amer	
0 :	or its		1 Never Married 2 Married 1 Yes 2 No		tican, etc.)	Black, White	Name .
	el, o	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW. ☐	1 ☐ Yes 2 ☑No Specify:		Specify: W/M	1/6
ה ה	n /z nours "natural", edical Exe	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workin	16	b. Kind of Business/I	ndustry
	L L	e d	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	-	. =	August
7	giene Frank	Ö	12	ENAMEBLAIZ		AMERICAN	STANDARD
2	oth oth	a	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>a</u>	ked ked lc e	To B	JOHN F TRABERT	MAR	V UI	UK	
<u> </u>	nd N nd N		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rural	Route Number, C	City or Town, State, Zi	p Code)
Ξ :	27 Is		ROBERT M. TRABERT	7609 Old HARFORD	Rd. BA	1to Md	21234
ā,	s 1 and 2 should I Health and Mer Item 27 Is marke other treumetic		20a Method of Disposition 20h Place of	Disposition (Name of	ate 20	c Location - City or T	our State
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-	. 5 9 2		21. Signature of Funeral Service Licensee				
Dair	Depart Depart Import any in		I hue M Strll.	22. Name and Address of Facility 75-27 HARFOLDS	1. BAI	timber 1	nd-
	DO SOL		234 Part Enter the disease or complications that raused the death. Do o	ot enter the mode of dying such as cardiac of	recouration arrest	e// /4	Approximate
			23d Part Enter the disease, or complications that caused the death. Do n shoot, or heart failure. List only one cause on each line.	L A	respiratory arres	"	Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	rt failler			
	/Medical Examiner		Du To (or as a consequence of	f):			
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	sit a	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events	n).			V
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	ed fo	SICI	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
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ທີ່	requires that leen signed b hould be deta	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to	
0.00	adult Bu Si	ed	Imphysema		1 🗆 Yes	2 □ No 3 □ Pro	bably 4 📆 Unknown
ပ် မ	as be	ple	0 1		24a. Was an	24b. Were aut	opsy findings available
r ,	ate ha	ompleted			autopsy perform 1 Yes 2	d? death?	ompletion of cause of
	certificate rector, pag	O	25. Was case referred to medical	26. Place of Death		3140 123 163	20.70
> :	Attending Priystcten: r death. ector: After this certific by the funeral director.	.0	examiner? 1 Yes 2 No Hospital: 1 Inpatient FR/Out	Othor		ce 6 ☐Other (Speci	(b)
0	arthi eral	L L	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at 2	8d. Describe how		
0	tru After	읥	1 Matural 5 □ Pending (Month, Day Year) In 2 □ Accident investigation	ijury Work? M 1 □ Yes 2 □ No			
DIVISION	Atte	fice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far	m, street, factory, office 2		et and Number or Run	al Route Number,
5 .	after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physical within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di		29a. Certifier 1 Certifying Physicien: To the best of my knowledge	, death occurred at the time, date and place, a	nd due to the cau	se(s) and manner as	stated.
;	e Full e Full etely	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated.	Vor investigation, in my opinion, death occurre	d at the time, date	and place, and due t	to the cause(s)
:	withir To th	Me	29b. Signature and title of certifier	29c. License number	290	l. Date signed (Month,	Day, Year)
, '	->-0		Mari Kan De La	A3//122		1-27-04	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type Print)		~/07	
	ð		1. ROWALEUSKI MID 7672 RET	oin hel Karry	UN. 212	36	
lk ₁	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	B 10 10 1/1	-17-1	- 70	
	Registr		JAN 2 9 2004 Marco De 1	29c. License number B 2 10 2 2 Type, Print) AIN Wel SACTO			

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		1	For State Registrar	State of Maryland /	Depai <i>Cert</i>	tment of Heificate of D	ealth and N Death		giene 0 0	4 02194
	Physicia	an	1. Decedent's Name (First, Middle, Last)	To stanoski				2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stre	emonal Hosp	tal		re de Gr	ace	4c. County of E	ford
	Funeral Director		5. Social Security Number 6. Sex 161-05-3944 XX M	7. Age (In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Birth	1978 P	Birthplace (State or Foreign County) Ennsylvania
	pu >		Usuel Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	ation				10d. Inside City Limits
	Aanyla I show	٥	MD Harford	Havre						1 □ Yes 2/10 No
	28e-	rect	10e. Street and Number		-	10f. Zip Code			10g. Citizen of Wha	t Country?
	h with	al Di	110 Unit E Bayland	d Dr.		21078			USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie marked other then "naturei", or items 23a or 28e-1 show any injury or other treumatic event, I'm Medical Eranfraf must be notified in ance.	by Funeral Director	11. Marital Status 12 1 Never Married XX Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 BYes 2 □ No If Yes, Give J Year or DatesWII	lf '	as Decedent of His Yes, specify Cuban	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)		American Indian, White, etc. Thite
Maryland 21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give k	ent's Usual Occupatind of work done di O NOT use retired) Ker	tion uring most of wor		16b. Kind of Busin Bethlehen	
land 2	uld be filed Aental Hygi rked other tic event, t	To Be Co	17. Father's Name (First, Middle, Last) Peter Tostanoski	· ·				ne (First, Middle, Klaczko	Maiden Sumame) WSka	
lary	2 shore and h ie ma euma		19a. Informant's Name/Relationship (Type						r, City or Town, Sta	
e,	1 and tealth am 27 ther tr		Louise Tostanoski 20a. Method of Disposition	20b, Place	of Dispos	ition (Name of		r Havre	de Grace, 20c. Location - Cit	MD. 21078 v or Town, State
Baltimore,	Pages Iment of Hant: If ite jury or of		1	cemet	iery, crem ney V	atory or other place alley Men	1/30	0/2004	Dulaney	Valley MD
Bal	permit Depar Impor any in		21. Signature of Euneral Service Licensee		12		o Avenue		dale Fune le Maryla	ral Home nd 21237
	March Wiles		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the death. Do	not ente	r the mode of dying	, such as cardiac est	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	e of):	-0-	-3 -			
ı	Examiner	<u></u>	Sequentially list conditions, b.	Due to (or a) a consequence		2				
100	ecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
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Jo	Phyei this or	2	1 Yes 2 No	1 Manpatient 2 LERV	Outpatient Time of	3 DOA	4 Nutsing n		dence 6 Other (Specify)
lon	nding Phy th. : After thi e funeral	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work M 1 ☐ Y	? ′es 2 □ No		.,	
Divisi	To the Hospitel or Attending Phyeicien: within 24 hours after death. To the Funerel Director: After this certification completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number o m, State)	or Rural Route Number,
	e Hospit 24 hours e Funere letely fille	Medical C		r: On the best of my knowled r: On the basis of examination and manner stated.						
•	To th within To th	Me	29b. Signature and title of certifier	M.D		29c. License			29d. Date signed (A	
	W.	18	30. Name and address of person who com	pleted cause of death (Item 23a In Ion Avenue		Print) +(aV	ede	Grace	1/25/ MD 21	078
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 9 2004	32. Registrar's Signature	A.	all s				

Na		1 - State Amend Item# 1 Registrar 1. Decedent's Name (First, Middle					e of L	Jeath		2. Date of Death		Vear	3. Time of Deat
nysici: Medic					VOIKIII					Janua	ary 15, 20		10:00
kamin	er	4a. Fecility Name (If not institution, How	give street and numb ard County Ge		spital	4b. City,	Town, or	Location of		umbia	4c. County		loward
neral ector		5. Social Security Number 214-46-1546	6. Sex 7	. Age (In yrs.	last birthday) 56 Yrs.	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, Y October 3,		9. Birth Cou	plece (State or For ntry) Maryland
120		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Li
a pail	to	MD B	altimore City				Ва	ltimore (City				1 Yes 2
Le noti	i Director	10e. Street and Number 717 Devonshire Ro	ı.			10f. Zip	Code	212	229	10g	. Citizen of V		ntry? S.A.
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	To Be C	17. Father's Name (First, Middle, Henry Harry Clement Halbi	(Clement Halb	i g				18. Mother	s Name	(First, Middle, Ma Elizabeth	iden Sumam 1 Gertrud	,	er
other treumatic ev	-	19a. Informant's Name/Relationsh Ms. Elizabeth Jac	nip (Type, Print)	ughter						Route Number, Core, MD 212		State, Zi	o Code)
ō		20a. Method of Disposition 1 ABurial 2 Cremation 4 Donation 5 Other (Sp.			Place of Dispondermetery, created Sound S	natory or o	other plac		1 - 2	ate 20	c. Location - Ellic		own, State y, Maryland
eny injury QDCs.		21. Signature of Funeral Service	icensee	V120	22	. Name ar	nd Addres Slack 3871 (Funeral Old Colu	Home		City, MD	21043	3
the burial-transit	I Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a consecura as a consecura as a consecura as a consecura as a consecuration of the conse	quence oi).	uns	Can	a (404	the 1300	2 in	5	Ohset and Dea
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page 2	Completed										d? g	rior to co	opsy findings avai empletion of cause 2 No
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After this funeral di	H	27. Manner of Death 1 Natural 5 Pendin	28a. Date of (Month		28b. Time of Injury		28c. Injun Worl		2	ne 5 Residence 8d. Describe how			ry)
Director: A d in by the fu	Certification;	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of	of Injury - At h g, etc. <i>(Speci</i>	iome, farm, str fy)	eet, factor	y, office		2	8f. Location (Stree City or Town,		er or Rur	al Route Number,
To the Funeral Direct completely filled in by	ledicai C	29a. Certifier (Check only one) 1. Certifyin 2 Medical	g Physician: To the base Examiner: On the base and manner	sis of examina	owledge, deatl ation and/or in	n occurred vestigation	at the tim	ne, date and pinion, death	place, a	and due to the caused at the time, date	se(s) and ma a and place, a	nner as :	stated. o the cause(s)
To th	Me	29b. Signature and title of certifier	11. Boul	ulas	(ms	290	c. License	850	a	29d	Date signed	(Month,	Day, Year)
	1	I LUDIO L	1 4 1	of death (ite					- 1	1	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registras Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WORREL 0340 a M 2004 EGINA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** DALTIMORE UNIVERSITE PECIALTY HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Yrs 8-22 Director MARCH 25, 1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show treumatic event, the Madical Examiner must be notified at 1/2 Yes 2 □ No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 60 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No <u>م</u> Specify: 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GHAGRADE DWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event 2008. Be LARENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE AWYER WORRELL 607 GIBSON HUSBAND) 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 3 ☐ Other (Specify) ARBUTUS MEM. PARKO1-28-04 9 ☐ Other (Specify) 21. Signature of Fune al Service Lights 22. Name and Address of Facility 40.2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an est, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL LN FARCTION Physician /Medical Due to (or as a consequence of): Examiner CARRIOVASCULAR DISERSE STYRS ARTERIO SC LEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ THAL AMIC PER TENSION GASTROSTOMY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? MYECHRDIA 24a. Was an certificate has autopsy performed? IRACHEOS TO MY 1 ☐ Yes 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide

Baltimore, Maryland 21215-0036 NORRE Division of Vital Records, within 24 hours after death.

To the Funeral Director: Af the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) James P. Flynn DO 1346 un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.CHARLES J. FLYNN. MO UNIVERSITY SPECIALTY HOSPITAL 36 Registrar's Signature Cook 31. Date filed (Month, Day, Year) State JAN 2 9 2004 Registrar DHMH 17 Rev 1/2001

		•	1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death		iene g. No. 2004	02197
			Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Time of Death
	Physici /Medic		LEGERTHA		WESLEY	Jainua M	25, 2004	11:35 A M
	Examin		4a. Fecility Name (If not institution, give s	street and number)	4b. City, Town, or Location of Dear	h	4c. County of Deeth	
			The Johns Hope		Baltimole City v) If Under 1 Year II Under 24 Hrs	T2		
85	Funeral Director		5. Social Security Number 6. Sex 15	7. Åge (In yrs. last birthda 43 Yrs.	y) If Under 1 Year II Under 24 Hrs Months Days Hours Min		Year) 9. Birthp Count GO AIAK	place (State or Foreign htry) Dama
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		1	0d. Inside City Limits
	Maryi	ö	mo	BACTIN	nare			1 ☐ Yes 2 ☐ No
	r 28a	rec	10e. Street and Number	10/10/11	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f ehow r.n.ust be notified at	a D	5711 Chinavapor	Partway	21239		USA	
	ams ams	ıner	Tr. Mariar States	12. Was Decedent Ever in U.S. 13 Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
920	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 ehow or other traumatic event, the Madical Examinar man for notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 Ø No II Yes, Give Year or Dates:	1 ☐ Yes 2 III No Specify:		Specify: B1	ACK
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ان ت	Hygier ther th		17. Father's Name (First, Middle, Last)	dyrs	18. Mother's Na	m <i>e (First, Middle, N</i>	Naiden Sumame)	
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ary	2 should and he is man		19a. Informant's Name/Relationship (Ty		iling Address (Street and Number or R	- 10	111.000 011	
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Baltimore	Peges nent of Hant: If its		1 12 Burial 2 Cremation 3 R	emoval from State cemetery, co	rematory or other place)			
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	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1			O annother
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Вох	that the death certif ed by the attending detached for use a:	Iclan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	B Ectopic pregnancy C Other (specify)		Month Month	Day Year
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<u>a</u>	ician: Th certificate rector, pag	C	25. Was case referred to medical	<u> </u>	26. Place of De	1 ☐ Yes 2 ath (Check only one	No 1 Yes	2D(No
>	y S	To B	examiner?	lospital: 1 Inpatient 2 ER/Outpat	Other		nce 6 Other (Specify	y)
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Division	or Attendation of the order of the order of the order of the order of the order of the order of the order of the order of the order	ertification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, lactory, office	City or Town,	eet and Number or Rura , State)	i Houte Number,
	To the Hospitel or At within 24 hours after or To the Funeral Directom letely filled in by	edical C	29a. Certifying Physical Certifying Physical Cartifying Physical Examione)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as si ite and place, and due to	tated. the cause(s)
	Totle within 2 Totle com: let	Σ	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month,	Day, Year)
•	-		DAUCSON JAUCSON	MD	RES - 000	10	inuary 25, 2	2004.
	K		30. Name and address of person who co	empleted cause of death (Item 23a) (Typ	e, Print)			
			31. Date filed (Month, Day, Year)	32. Registrar's ignature	Hay GOO HATTE V	volte Street	a hmw Min	11/2.7
165	Sta Registi		31. Date filed (Month, Day, Year)		& hours			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** WEISS, EDWARD Τ. January 20 2004 9:45 A.M -/Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Medical Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1X M 2□ F Yrs. 50 March 28, 1953 Director 578-74-7937 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28e-f show any Injury or other traumatic event, the Madical Examinal must be nutitled at 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No Directo Maryland Prince George's Bladensburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4239 58th Avenue, Apt #3 20710 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White <u>م</u> 3 ☐ Widowed 4 ₺ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Water Proofer Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elsie Chroniger Charles Phillip 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4208 53rd Avenue, Apt #2, Bladensburg, MD 20710 Elsie Chroniger/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME Kildled Mo1322 3401 Bladensburg Road, Brentwood, Maryland 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner EXCACERBATION bhysician and the buriel-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): ettending | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 1 Yea 2 No 3 Probably 4 Inknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed certificate has Yes 2 🗆 No 1X Yes 2□ No al or Attending Physiclen: Tos efter death. In Director: After this certificet illed in by the funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital 24 hours to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely i within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL CHEVERLY. MD TSION DERHANE 3001

Signature

State Registrar

			1 For State	State of Ma	ryland / Depa		lealth and M	lental Hygi	ene 2 (ible.	02190
	Physic /Med	ical		nter, Sr.	Ger			2. Date of Death Month	Day 22	2004	3. Time of Death
	Exami Funeral		5. Social Security Number 6. Sec	HEALT 7. Age	HCARE (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth		y of Death N/A	A ace (State or Foreign ry) r Land
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	Sta	ate	30. Name and address of parson who con CYC 31. Date filed (Month, Day, Year)	LOPEA A	MAKOUA	900 C	STON AVI	E, BALT	TIMOX	RE N	1 21229
	Registr		JA	2004	Signature	S. Apr	and I				

		For State of Mar Registrar	yland / [Department of F Certificate of			ene 2004	02200
Physiciai /Medica		1. Decedent's Name (First, Middle, Last) Alexander Wierciszewski	;			2. Date of Death Month	Day Year 23, 2004	3. Time of Death
Examine Funeral Director	r	216–10–1013 1晃м 2□ F		thday) If Under 1 Year	T	8. Date of Birth (Month, Day, Y 08/ 20/	4c. County of Death (ear) 9. Birth Cou	nplace (State or Foreign intry)
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	- 11	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. T	ime of 28c. Injury	/ at 28	e 5 Hesidence	e 6 Other (Special injury occurred	y)
ital or Attending P irs after death. ral Director: After fled in by the funera	20111111	4 Homicide building, etc. (Specify)	m, street, factory, office		City or Town, S		
the Hosp in 24 hou the Funer ppletely fil		29a. Certifier (Check only one) 12 Certifying Physician: To the best of model of the pass of examiner: On the basis of examiner and manner stated	amination and	Vor investigation, in my of	pinion, death occurred	d due to the cause d at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
Vithi Vithi Com		29b. Signature and title of certifier 30. Name and address of person who completed cause of deat	h (Item 23a) (29c. License \$200.5			Date signed (Month, many 24, 5 HOPV.)	•
State Registra		AAYVIEW CINCLE BALTI 31. Date filed (Month, Day, Year) JAN 9 0 2004 Salarian's	MORE	MD 2127	24	. , , .	1 4 1	· ·
DHMH 17 Rev 1/200		2004	and .	GINAL GINAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Norman Edward White January 25, 2004

Street
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

4b. City, Town, or Locetion of Deeth

1:30 PM

Harford

9. Birthplace (State or Foreign Country)

4c. County of Deeth

Physician /Medical Examiner

4a Fecility Name (If not institution, give street and number)

3038 Conowingo Road

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Physician /Medical

Examiner

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

ral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under 24 Hr Hours Mir		rth av. Year)	9. Birthplace Country)	(State or Foreign
tor	212-50-6414	1 ⊠ M 2□F	56	S Yrs.	IN GARCIE	Dayo	110010		4, 1947	Maryla	ınd
	Usuel Residence of Decedent		10.00						•		
5	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						nside City Limits
Director	Maryland Harfo	ord	St	reet						1	☐Yes 2√2No
흔	10e. Street and Number				10f. Zip	Code			10g. Citizen of	Whet Country?	
	3038 Conowing	go Road				2115	4			USA	
Funeral	11. Marital Status	12. Wes Dec	edent Ever in U,	S. 13.				Specify Yes or N rto Rican, etc.)	o- 14. Rad	e - American Inc	dian,
2	1 Never Married 2 Marr	ied Armed Fo	2 No					rto Rican, etc.)	Bla	ck, White, etc.	
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	re ates:		1□Yes 2	No.	Specify:		Specify	_{y:} Whit	.0
8	15. Deceden	t's Education		16a. Deced	dent's Usua	I Occupa	ation		16b. Kind of B	usiness/Industry	
ple		st grade completed)	4 5-1	(Give	kind of wor DO NOT us	rk done d se retired	furing most of w	o <i>rki</i> ng			
Completed	Elementary/Secondary (0-12)	College (-40r 5+)	Rody	z Fenc	der 1	Mechanio	٦	Automo	tiro Do	nair
	17. Father's Name (First, Middle,	Last)		Dody	<u> </u>	ACL 1			, Maiden Suman	tive Re	Parr
o Be	James Silas	White					Ruth	Vivian	Thompso	'n	
2	19a. Informant's Name/Relations			19h Mailir	ng Address	(Street			per, City or Town,		a)
8									on, only or rown,	State, Zip Code	,
	Patricia White 20a. Method of Disposition	e / Wife	20h P	3038 lace of Dispo	CONOV	vinge	Road,	Street,	Marylan	d 21154 City or Town, S	itata
5	1X Buriel 2 Cremation	3 Removal from	State	em <i>etery</i> , crer	natory or o	ther place	•				
	4 □ Donation 5 □ Other (S	pecify)	Bel						Bel Air	, Maryl	and
ODCe.	21. Chature of Funeral Service	Licensee	A.	22 N	Name and	d Addres	s of Facility	Iome, P.A	Δ _		
i a	Relive I K tom	ion Itoms	حدار						ngdon, M	aryland	21009
	23e. Fert1. Emer the disease, or	complications that of	aus the death							Appr	roximate
an an	shock, failure. List	only one cause on e	ecn ne.							Onse	val Between et and Death
cal	Immediate Cause (Final	>			1-61		· .				
ner	disease or condition resulting in deeth)	a. 1716				>(1)	TU CE	L UN	G CAN	ER 7	MOUTH
ē 183				r as a consec							
두		b		EFT		<u> </u>					
Xai	Sequentially list conditions, if any, leading to immediate		Due to (or	as e conseq	uence of):					1	
<u>e</u>	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	с									
ğ	resulting in death) Last		Due to (or	as e conseq	uence of):					1	
Š	,	d									
eted by Physician/Medical Examiner										1	
ysic	Part II. Other significant condition	ns contributing to de	ath but not resu	ılting in the u	nderlying ce	use give	n in Part I.	23b. Did	tobacco use cor	ntribute to the o	ause of death?
문								1页	Yes 2□ No	3 Probably	4 Unknown
by								-			
ţ.									an autopsy ormed?	available	topsy findings prior to
e e	-									of death	on of cause
, E								10	Yus 254Nc	1 ☐ Yes	2 (X (No
O	25. Was case referred to medical						26 Place of Do	ath (Check only			
80	examiner? 1 ☐ Yes 2 █ No	Hospital:	npatient 2 🗆	ER/Outpatien	t 3□ DO	Othe			dence 6 □Oth	os (Coopifu)	
<u> </u>	27. Menner of Death	28a. Date 0		28b. Time of		Bc. Injury Work		1	how injury occurr		
Fi	1 Naturel 5 Pendin	g (Mont	h, Day Year)	Injury	м		? ′es 2 ∐ No		, , , , , , , , , , , , , , , , , , , ,		
ca	3 Suicide 6 Could r	not be	of Injury - At ho	mo farm etr				28f Location /	Street and Numb	er or Pural Pour	to Number
ŧ	4 ☐ Homicide determ		ng, etc. (Specify		et, lactory	, OHICE			wn, State)	er or nurar nour	e Nulliber,
ပိ											
ca	(Check only 2 Medicai I	g Physician: To the Examiner: On the ba	sis of examinat	vledge, death ion end/or inv	occurred a estigation,	it the time in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	date and place, a	inner as stated. and due to the c	ause(s)
Medical Certification: To Be Compl	one)	and manr	er stated.								
2	29b. Signature and title of certifier					License			29d. Date signed		
*	- Kel	larae	lau	MI	> 2	45	532		1-27-	-2004	
0	30. Name end address of person		e of death (Item	23e) (Type, I	Print)	,				1	~ /
'	5- SIVASAILA		, SAW	DPIPE	RC	IRCL	EI SU	1.TE 211	1-27-	-213	23/0
State	31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ure							

DHMH 16 Rev 6/95

Registrar

JAN 2 9 2004

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200

							(Certific	ate o	of L	Death			Reg. No	. 20	104	0	2202
	D1 : :		1. Decedent's Name (First, Middle	, Last)							·		2. Dete of De Month	eth De	ev	Year		e of Death
	Physiciar /Medica		Jack Marvi	n I	Wilson	1							Innymy	2	-	2004	70	OAM
À	Examine		4e Fecility Name (If not institution							4	b. City, To	wn, or Lo	cation of Death	40	. County	of Deeth		
			2511 Willoughb	у В	each I						Edger					arfor		
	Funeral		5. Social Security Number	6. Sex	M 2□ F	7. Age (/	In yrs. last birth	Mon	nder 1 Ye	ear eys	If Under a	Min.	8. Date of Bir (Month, Da	th ly, Year,)	9. Birthpl Count	ace (Sta	ate or Foreign
	Director	-	218-32-1382				69 ^Y	s.					May 30,	19.	34	Vir	gin:	ia
	pue *	ŀ	Usuel Residence of Decedent 10a. Stete 10b. County			10	0c. City, Town	or Location								10	d. Insid	le City Limits
	f she	0	7 7 7				77.3										1 🗆	Yes 2√∏ No
	the 28a	Director	Maryland Harf 10e. Street end Number	ora			rage	2WOOd	, Zip Cod	de	-			10g. Ci	tizen of V	What Count	ry?	
	Sa or		2511 Willoughb	37 B	each I	hso?		:	2	104	40				US.	A		
	me 2	Funeral	11. Merital Status		2. Was Dec	edent Eve	er in U,S.	13. Was D	ecedent	of H	ispanic Orig	gin? (Spe	cify Yes or No	-	14. Rac	e - America		n,
0	or He		1 ☐ Never Merried 2 ☐ Marr	ed	Armed F	2 X No			specify t es 2⊠			, Pueno	Rican, etc.)			ck, White, e	tc.	
00	Brant, C	2	3 Nidowed 4 Divorced		If Yes, G Year or D	ve Dates:		1 11	s ZŁW	140	Specify:				Specify	" Whi	te	
21215-0020	within 72 hours after death with the Marylend ene. than "natural; or items 23a or 28a-f show he Medical Examiner must be rectived at	Completed	15. Deceden (Specify only highes	's Educ	ation completed))		ecedent's Give kind o	f work do	one d	durina most	of worki	ing	16b. K	(ind of Bu	usiness/Ind	ustry	
21	ithin	ᇍ	Elementery/Secondary (0-12)		College (ife. DO NO			•			_				
7	el Hygiene. I other than vent, the Ma	ទី	10				Mac	chine	Ope:	ra		do Nome	(First, Middle			anufa	ctu	rer
anc anc	d off	8	17. Father's Neme (First, Middle,		- · -											10)		
Ĕ	should and Men marke umaric	<u>∘</u>	Wiley Haywood 19a. Informant's Name/Relations			NILSC		Anilian Ada	leans (Ct	root	Oll		Gay Fu al Route Numb	ılle		State Zin	Cadal	
Maryland	C1 00 00 00	1	Jack Michael Wi			an a							, Joppa				Code	
	1 end 1 Health em 27	+	20a. Method of Disposition	130	11 / 5		20b. Place of I	Disposition	(Name o	of		1	Date	_		City or To	vn, Stat	е
<u>ō</u>	Peges nent of ant: If it ury or o		1 Burial 2 ☐ Gremation 4 ☐ Denglion 5 ☐ Other (S	3 NRe	emoval from	State		crematory				 1	-30-04	To		Max	1 220	٦
altimore,	F 48 3		21. Sign the of the eral Service	-	e		TTIIIL								LPU,	магу	Lair	
Ba	permit. Depentingort any inj	-			1								me, P.A			D 210	0.5	
		\dashv	23e Part Lever the disease, or	complic	ations that	caused the	e death. Do no	t enter the	/ CO	Ke dvin	Sbury	ROA cardiac d	d, Abir	ngao: rrest.	n, M	D 210	8 り Approx	mate
1	Physician		23e Parti. Elijar tie disease, or shock, or heart failure. List	only one	e cause on	each line.				•							Interval Onset a	Between and Death
)	/Medical		Immediate Cause (Final		(1.]		
	Examiner		disease or condition resulting in death)	Θ.		Du	e to (or as a co	nsequence	on:	1	lung							
	D 55							·			V					1		
	certificate be executed rding physician and use as the buriel-transit	Examiner	Sequentially list conditions, if eny, leading to immediate	Б.		Du	e to (or as a co	nsequence	of):							1		
90,	sian a	<u>ב</u>	ceuse. Enter Underlying Ceuse (Disease or injury	C												1		
68760,	cete t	edical	that initieted events resulting in death) Last			Du	e to (or as a co	nsequence	of):							1		
×	ding I	Ξ		d.														
Bo	w requires thet the death or been signed by the ettend should be deteched for us	Physician											001 014		200			4 44-0
P.O.	requires thet the death seen signed by the etter hould be deteched for u	28	Part II. Other significant condition	ns cont	ributing to d	leath but n	not resulting in	ne underly	ng cause	e giv	en in Parti.			Yes 2				se of death?
σ.	thet ned b	2	Hyperles	se	on								"	103	2 140	0041100		
rds	n sign uld by	8	//										24a. Was	an auto	psy		re autop	osy findings
၀	law rec			-									penc	iniou:		con		of cause
æ	The law	Сотріете											1031	Yas 2	₩ No	1	Yes	2 No
<u>ta</u>	certificete	De l	25. Was case referred to medical								26. Place	of Death	Check only	one)	-			
† <	Physician: this certific ral director,	0	examiner? 1 Yes 2 No	Ho	ospital: 1 🗆	Inpatient	2 ER/Out	etient 3	DOA	Oth	er: 4□ Nu	rsing Ho	me 5 🗷 Resi	dence	6 □Oth	er (Specify	,	
0 _	ng Ph Iter th Inera	Ë	27. Manner of Death 1. ■Natural 5 □ Pendin	0	28a. Date (Mor	of Injury oth, Dey Y	'ear) 28b. Ti	ury	28c.				28d. Describe	how inju	iry occur	red		
Sio	Attending or death.	Cati	2 ☐ Accident investig	ation				М	-		Yes 2□I					_		
Division of Vital Records,	i or Attending P effer death. I Director; After t d in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could (4 ☐ Homicide determ		28e. Plac build	e of Injury ling, etc. (- At home, fari 'Specify)	n, street, fa	ctory, off	fice			28f. Location (City or To			er or Hurai	Houte .	Number,
	Hospital of Punctual Distriction of Punctual Districti	2	29a. Certifier 1☐ Certifyin	n Dhuai	clan: To the	heet of -	ny knowledge,	death occur	rred at th	ne tin	ne date an	d place	and due to the	Cause/s	s) and ma	nner se et	nterd	
X	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical			er: On the b		amination and											se(s)
1,	Fo the Within Fo the compl	Σ	29b. Signature and title of certifie						29c. Lic	cens	e number		Line	29d. Da	ate signe	d (Month, L	Day, Ye	ar)
	> - 0		Rama D A	· V.	B.	rin	MAIR		000	1	4.20	6	- Table	10-		77 21	04	
	1:		30. Name end eddress of person	who con	npleted cau	se of deet	th (Item 23e) (1				420		y	a There	fre d	1, 00	-/-	
	jo		BERNARD J. YUK	NA			7108 H	LABIN	20 /	AVE	BA	LTO	Md Z	122	2			
	State		31. Date filed (Month, Day, Year)		4	4,	Signature	AN BI	n#									
	Registra	r	JAN 25	206	34 1	Contraction	15	4	V									

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:22 PM JANUARY Franklin Xega 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner AGNOS BALTIMORES HISAUTH CARES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 28, 1937 Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 10XM 2□ F Albania 66 163-76-4084 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "naturs!", or itama 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Howard Elkridge the 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21075 6556 Elderberry Court United States Funerai 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "1 any intry or other traumatic event, the Next once. Elementary/Secondary (0-12) 12 than College (1-4or 5+) 4 Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mihal Xega Kleonigi Mukelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Xega - Wife Elkridge, Maryland 21075 6556 Elderberry Court Oeti 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 1/31/04 Elkridge, Maryland 4 Donation 5 Other (Specify) Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Gary L. Kaufman Funeral Home

7250 Washington Blvd. Elkri

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Setween Onset and Death Immediate Cause (Final Hypovolemic Physician 10 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 10 hours, ABDOMINAL CATACTROPHY Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown peen 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No has certificate 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 SNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: the 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funeral Direct 4 Homicide 5 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 27, 2004 NASCOD 1216766 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD O MASCOD, MD CATONS AVENUE BALTIMORE 00 31. Date filed (Month, Day, Year)

JAN 2 9 2004 32. Registrar's Signature

Registrar

XEGA, FRANICIN

			1 - For State Registrar	State of Ma		partment o		nd Mental H	ygiene Reg. No	71111	02204
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Rose Marie Ye	eager				2. Date of I Month Janua	Da	200%	3. Time of Death 5:16a M
	Examin		4a. Facility Name (If not institution, give 5428 Jim Pickett				wn, or Location of	Death	4	County of Dea	ith
	Funeral Director		210 20 0000	x 7. Age	(In yrs. last birthda Yrs.	Months D	ear If Under 2 ays Hours	Min. 8. Date of 8. (Month, 1. Sept.	Birth Day, Year) 18 19	9. Bi	thplace (State or Foreign ountry)
	Maryland f show	ŏ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Sykesvil						10d. Inside City Limits
	s with the 3a or 28e-	I Direct	10e Street and Number 5428 Jim Pickett	Road		10f. Zip Co	de L784		10g. Cit USA	izen of What C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, it a Medical Erathinar must be rediffed at ODGs.	by Funeral Director		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:		. Was Decedent If Yes, specify	Cuban, Mexican,	in? (Specify Yes or f Puerto Rican, etc.)	No-	14. Race - Am Black, Whi Specify: Wh	te, etc.
Maryland 21215-0036	d within 72 ho giene. er then "netur r the Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Giv	edent's Usual O re kind of work d DO NOT use re omemaker	fone during most etired)	of working		ind of Business	VIndustry
yland	ould be fite Mental Hy arked other	To Be (17. Father's Name (First, Middle, Last) Vincent Richard	Catano				's Name (First, Middi ian Meliss			
	and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationship (Ty Dinah Thompson (d		5428	Jim Pic	ckett Rd	or Rural Route Num ., Sykesvi	ille,	Md 217	84
Baltimore,	Pages 1 Iment of H Itel		20a. Method of Disposition 1 37Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)		Lake Vi	ematory or other ew Memor	rplace)	Date -29-04	Syk	esville	, Md
Ball	permit Depart Import any in		21. Signature of Funeral Service License Paramalogy		Haight Fur kesville,			Chape1			
· 秦	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	LAYVA	θ.		0.1	monky	1	line	Approximate Interval Between Onset and Death
· ·	3	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):	<i>y</i> 11	VIDO (H2			
O. Box 68760,	ath certificate titending phy or use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d. 3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	□Ectopic pregn				23d. Date of de Month	livery Day Year
Records, P.O.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	ntributing to death but	t not resulting in the	underlying cause	e given in Part I.		tobacco u		o the cause of death?
	Physician; The law rethis certificate has bee	Completed							opsy formed?	24b. Were as prior to death?	utopsy findings available completion of cause of
Division of Vital	nding Physiciar ath. r: After this certif e funeral directo	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time	of 28c.	Other	of Death (Check only sing Home 5 X Re 28d. Describe	sidence (city)
Divis	el or Attens s after deatl at Director: ad in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, tarm, s (Specify)	treet, factory, off	fice	28f. Location City or T	(Street an own, State	d Number or Ri	ural Route Number,
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)	Tot Tot	Σ	29b. Signature and title of certifier	liga m	D	29c. Lic	cense number		1	e signed (Mont	04
	30		30. Name and address of person who co	349	nalcol	1 1	2, h	vestm.	ins	Ler 1	ND 01157
	Sta Registr	15	31. Date filed (Mg/Ath/Pay2Yey) 2004	4 Registrar	r's Signature	soft.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAÑÜÄRY 2004 MARGARET YOUNG EASON 3:55 P.M. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL FOREST HILL.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Dec. 12, 1 HARFORD Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 夕 F 85 Director 212-07-6753 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Harford 1 ☐ Yes 2€No Fallston Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? or Itams 23a or 1807 Arabian Way 21047 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 □ Divorced "natural", Completed 15. Decedenl's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men 20fice. Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12 Public Schools Dietician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William (NMN) Eason Nettie (NMN) Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta M. Sailer/Daughter 1807 Arabian Way, Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State '4 □Donation 550 Other (Specify) Entombment Parkwood Cemetery 1-26-04 Baltimore, MD ^{22.} Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 21. Signatur of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications three death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in schline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ementia resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Leader July that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 □Unknown 1 Tes 2 1 NO Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed page 2 🗔 No 25 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpalient 1 Yes 2 No Other: Certification: To 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannerof Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 14 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner slated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed c tem 23a) (Type, Print) XZXTI MXNUT2 ~ 31. Date filed (Month, Day, Year)
JAN 2 9 32. Registrar's Signature State 2004 Registrar

			1 - For State Registrar	State of Maryla	and / Dep		Health and M	Mental Hyg	_	04	02206
	Physici -/Medio Examin	al	1. Decedent's Name (First, Middle, Last, Harriet 4a. Fecility Name (If not institution, give	AB RA	MS		or Location of Death	2. Date of Deat Month January	Day 12 2 4c. County		3. Time of Death 10:30P M
	Funeral Director				rs. last birthday Yrs.			8. Date of Birth (Month, Pay, April		9. Birthp Cour Nev	ry place (State or Foreign ptry) York
	ith the Maryland or 28a-1 show	Director	Usual Residence of Decedent	ry	City. Town or l	Spring		10	Og. Citizen of	What Cour	0d. Inside City Limits 1
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural; or items 23a or 28a-1 show other traumatic svent, the Medical Enumber must be notified at	by Funerai	918 S. Belgrad 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 U.S. 13		Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - Americ ck, White,	
Maryland 21215-0036	iled within 72 ho Hygiene. ther than "natur nt, the Wed call	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4or 5+)	(Giv	edent's Usual Occu e kind of work done DO NOT use retire inistrato	during most of work	king	Dept.	of I	dustry Prisons Justice
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	Physician /Medical Examiner		disease or condition resulting in death)		atic Br	east Cano					Onset and Death 3 years
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o	ing Phys After this uneral di	ation; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ome 5 Fesider 28d. Describe ho	nce 6 Oth)				
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	To the Hosp within 24 ho To the Fune completely fi	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of centiler	ner: On the basis of exam and manner stated.	ination and/or I	nvestigation, in my o	opinion, death occur	red at the time, da	d. Date signed	and due to	Day, Year)
	Sta		30. Name and address of person who confrederick P. Smith	1, MD 5454 32. Registrar's Sig	Wiscons	sin Ave.,	Suite 130	00, Chevy	Chase	, MD	20815
	Registr	ar	JAN 14 200	14	1	//					

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			1 - State	State of Ivialytal		rtificate of		-	Reg. No.	2001	02	207
			Registrar 1. Decedent's Name (First, Middle, Last	:)		rimouto o	Dodan	2. Date of De	ath		3. Time of	f Death
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	/Medic Examin		4e. Fecility Name (If not institution, give		-	4b. City, Town	or Location of De			County of Death	13.00	
			College View Cente	r		Freder			Fr	ederick		
	Funeral		5. Social Security Number 6. Se	TH OTHE		If Under 1 Yea Months Day		in (Month Da	th y, Year)	9. Birth Cou	olece (Stete ontry)	or Foreign
ì	Director		193-32-6206 Usuel Residence of Decedent	91	Yrs.			Nov. 20	, 19	12 Penn	sylvan	ia
	land		10a. State 10b. County	10c. Cir	ty, Town or Lo	ocation					10d. Inside C	ity Limits
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	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	ntry?	
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	ar dec	Funeral	11. Marital Status	 Was Decedent Ever in U Armed Forces? 	I.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? ıban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	-	 Race - Ameri Black, White. 		
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p	be tile d oth event	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	lam <i>e (First, Middle</i>	Maiden	Sumame)		
Maryland	Men Marke narke	ပို	Edward	Burke			Mildred			hoener		
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (T) William Anderson /	,	4			Rural Route Numb			Code)	
ō,	1 an Heall tem 2		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		rel, Mary		cation - City or T	own, State	
OL.	ages ant of nt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Hemoval from State	-	matory`or other p Cemetery		21/2004	001	n Ponn	ov 1	4.0
Baltimore,	përmit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Haalin and Mental Hygiene. Department of Haalin and Mental Hygiene. Privatoriant: If time 27 is marked other than *naturel; or Itama 23a or 28a-f ehow eny injury or other traumatic event. It is Madical Examana must be notified at Once.		21. Signature of Funeral Service Licens				ress of Facility	tauffer H	Tuner	al Home	sylvan e P Δ	1a
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	nsit	nine	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events			ANTEN	יות ר	FAIT			5 41	FAN J
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۵.	that the de ned by the a detached f	/ Ph	Part II. Other significant conditions co	intributing to death but not res	ulting in the u	nderlying cause	jiven in Part I.	23e. Did t	obacco u	se contribute to t	he cause of c	death?
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Sic	or Attend after death Director:	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome farm str		☐Yes 2☐No	28f Location (Street an	d Number or Run	al Route Num	ther
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	ne Hospital or A: 24 hours after or Eunerel Directles of the photos of		29a. Certifier 1 Certifying Phy	vsician: To the best of my kno	owledge, deat	h occurred at the	time, date and pla	ice, and due to the	cause(s)	and manner as s	tated.	
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			30. Name and address of the control of			Print)	ENGA	MIH	np	2170	2	
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

				State of Ma	iryianu /	Certifica		eaith and iv Death		eg. No. 2	106	02208
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Y	Examir	er	4a Facility Name (If not institution, give Kline Hospice Ho					b.City,Town,orLo Mt. Airy	cation of Death	4c. County	roll	
	Funeral Director		5. Social Security Number 6. Security Number 1214-48-2527		6 (In yrs. last b	Yrs. If Under Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) June 8	Year) 1947	9. Birthi Cou Mary	place (State or Foreign ntry) 7 Land
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location						10d. tnside City Limits
	Mary P-f sh	ţŏ	Maryland Frederic	ck	Fred	erick						1 Yes 2 No
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020	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Heme 23a or 28a-f show artic event, the Medical Examiner must be northed a	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:		If Yes, spe		spanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)		ck, White,	atc.
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ana		Be	17. Father's Name (First, Middle, Last)		1			18. Mother's Name	(First, Middle, I	Maiden Suman	10)	
ylar	should be and Mental marked o	ToE	Charles H. Anders					Iona St				
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	I or Atten after deal Director: d in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, (Specify)	farm, street, factor	y, office		28f. Location (St City or Town	reet and Numb n, State)	er or Rura	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funerel director, page 2:	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination a	ge, death occurred nd/or investigation	at the tim	e, date and place, oinion, death occurr	and due to the ca ed at the time, da	ause(s) and ma ate and place,	nner as s and due t	itated. o the cause(s)
	To the To the Comp	W	29b. Signature and title of certifier	1			c. License	number	2	9d. Date signe		
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	1		30. Name and address of person who do J.E. Asuncion, MD	completed cause of de 1564 Opc	eath (Item 23a) DSSUMTO	(Type, Print) wn Pike,	Free	derick, M	aryland	21702		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 6 2		r's Signature	\$ 1	par	Kn				

1			1 - State C	_	epartment of Health a Certificate of Death		giene Reg. No. 200	6 02210
	Physici	an	Decedent's Name (First, Middle, Last) Edward Benton Allor	· · · · · · · · · · · · · · · · · · ·		2. Date of Dea Month		3. Time of Death
)	/Medic Examir	al	4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or Location of	January Death	13, 2004 4c. County of De	1:45 P M
	Funeral Director	CI	2241 Aberdeen Drive 5. Social Security Number 218-78-1189 6. Sex	7. Age (In yrs. last birth	Crofton		Anne Ar	
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town				10d. Inside City Limits
	8a-f st	ector	MD Anne Arundel		Crofton			1 ☐ Yes 2 No
	ath with t	Funeral Director	10e. Street and Number 2241 Aberdeen Drive		10f. Zip Code 21114		10g. Citizen of What 0 USA	Country?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28a-1 show other traumatic event, Ite Medical Evarine mast ke ricitified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dec Armed Fc II Yes, Gir Year or D	2 🛣 No ve	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite etc. White
21215-0036	hin 72 h en "natu Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1.40(54)	Decedent's Usual Occupation Give kind of work done during most life. DO NOT use retired)			ederation of
	filed wit Hygiene other the		12 17. Father's Name (First, Middle, Last)	Com	puter Support An		State, Cou Municipal	
lanc	Mental Merked of	To Be	Kenneth Benton Allor			e Kathryn T	,	
, Maryland	1 and 2 should I Health and Meni em 27 ie marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Kim L. Allor/Wife	19b. 8 22	Mailing Address (Street and Number 241 Aberdeen Drive	or Rural Route Number e, Crofton,	r, City or Town, State, MD 21114	
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State cemetery,	Crenatory	an. 14, 2004	20c. Location - City of Baltimore,	
Bal	Depa Impo any ir		21. Signature of uneral ferror Littensee		22. Name and Address of Facility Barranco & Sons 495 Gov. Ritchi	, P.A. Seve e Hwy, Seve	rna Park E rna Park,	Tuneral Home MD 21146
	Physician /Medical		23a. Pay 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on a limmediate Cause (Final disease or condition resulting in death)	each line.	1	ardiac or respiratory arr		Approximate Interval Between Onset and Death
I	Examiner		Due to Sequentially list conditions, b.	(or as a consequence of):			
	l Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(b) d5 a consequence of).			
90,	licate be executed physician and s the burial-transit		that initiated events c c Due to	(or as a consequence of)):			
68760,		edicai	d					
P.O. Box	at the death certifi by the attending tached for use as	Physician/M	in the past 12 months?	come of pregnancy pirth 2 Fetal death lant at time of death lown	3 Dectopic pregnancy 5 Other (specify)		23d. Date of de Month	elivery Day Year
Records, P	The law requires that the te has been signed by the age 2 should be detache	by	Part II. Other significant conditions contributing to de	eath but not resulting in the	he underlying cause given in Part I.	23e. Did toi		to the cause of death?
		Completed				24a. Was a autops perform	sv prior to	utopsy findings available completion of cause of s
Vital	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	npatient 2 ER/Outp		of Death (Check only on		_{ecify)} at scene
Division of	ng Ph Ifter th Ineral		27. Manner of Death 28a. Date		ne of Corps 28c. Injury at work?	28d. Describe ho	w injury occurred	
/isio	Attendi death. ctor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm	1 ☐ Yes 2 N	28f. Location (St	t Shot St	
á	ital or arter		4 Homicide Buildi	ng, etc. (Specify)	- home	35 CAN 61 13 MA	Berden [rive
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2X) Medical Examiner: On the bi	best of my knowledge, of asis of examination and/oner stated.	death occurred at the time, date and or investigation, in my opinion, death	place, and due to the co occurred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
}	To th withir To th comp	Me	29b. Signature and title of certifier	- Rolle	29c. License number O.C.M		9d. Date signed <i>(Mon</i> January 14	**
			38 Name and address of person who completed cave		ype, Print) 111 Penn Street,	Doll-in-	W1	21201
100	Sta		31. Date filed (Month; Day, Year) 32.	oistrar's Signature	Analla	Baltimore,	_maryLand	21201
	Registr	al	JAN 1 5 2004					

			For State Registrar	State of Marylar	•		of Health a of Death			iene g. No. 2	004	02211	
ı	Physicia	an	Decedent's Name (First, Middle, Last)	Charles Hous	ser Alh	richt			2. Date of Deal Month	h Day	Year	3. Time of Death	
	/Medic	al	4a. Facility Name (ff not institution, give s		JCI 7110		vn, or Location	of Death	January	4c. Co	unty of Death	000	
	Examin	er	Washington County	_			rstown			Was	shingto	on	
	Funeral Director		5. Social Security Number 6. Sex		. last birthday) Yrs.	tf Under 1 Y		24 Hrs. Min.	8. Date of Birth (Month, Day, May 21,		9. Birth	olace (State or Foreign	
10%	D		Usual Residence of Decedent	100.0									
	be filed within 72 hours after death with the Maryland all Hygiene. I all Hygiene. I other than "natural", or items 23a or 28a-f show other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	20	10a. State 10b. County MD Washingto		ity, Town or Lo narpsbu							10d. Inside City Limits 1 ☐ Yes 2 No	
	28a-f	Director	10e, Street and Number	511 51	arpsoc	10f. Zip Co	de		1	0g. Citizer	of What Cou	ntry?	
	h with		2438 Dargan Road			217	82			Ţ	JSA		
	r deat	Funeral	11. Wantai States	Was Decedent Ever in t Amed Forces?	J.S. 13.	Was Decedent	of Hispanic Or Cuban, Mexicar	igin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,		
20	within 72 hours after ene. then "naturel", or fte te Medical Examine	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 □ No tf Yes, Give Year or Dates: 19!	52	1□Yes 2X	No Specify:			Sp	ecity: Whi	te	
3-003e	2 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual C	ecupation	t of worki	ng.	16b. Kind	of Business/In		
7	ithin 7	Completed	(Specify only highest grade	College (1-4or 5+)	life.	DO NOT use r	etired)	N OF WORK		II C	0		
77	filed w Hygier other th		17. Father's Name (First, Middle, Last)		Frec	tricia		er's Name	(First, Middle, I		Gover	nnent	
au		o Be	Charles Albrigh	nt			Es	ther	Houser				
ary	s 1 and 2 should f Health and Mer Item 27 is mark other traumatic		19a. Informant's Name/Relationship (Typ		. 1				I Route Number				
χ. Σ	and 2 lealth m 27 her tr		John F. Houser - 0		- 12 - 12 - 12 - 12	.8 Burl:					VIIIag	ge, MD20886	
E OE	8 ° = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cre	matory or othe	r place)				stown,		
Saittin			*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License				_		kles-Sp				
ñ	permit. Departi		Pat L. So	M97	0				pers Fe				
	Physician		23a. Part1. Enter the disease, or implice shock, or heart failure. List only on timmediate Cause (Finat disease or condition	eations that caused the real e cause on each line.	ith. Do not en	ter the mode o	f dying, such as	cardiac c	or respiratory arr	est,		Approximate the thermal Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	900	l a	1				1 Direct	
	Examine	_	Sequentially list conditions, b	Due to (or as a conse		cart	farber	e_				years.	
	uted 3 ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Dement	(a		V					Years.	
Ď	ate be executed hysician and the burial-transi		resulting in death) Last	Due to (or as a conse	quence of):								
8/PD	cate be executed physician and the burial-transit	dical	d	•						_			
X O	death certifica e attending ph of for use as t	νМе	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr	nancy					23d	. Date of deliv	erv	
. Box	0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown		⊒Ectopic pregr ⊒ Other <i>(speci</i>					Month	Day Year	
r Ö	that the de led by the a detached t	Phys	9 ☐ Unknown Part II. Dther significant conditions con		sulting in the I	inderhing caus	e gwen in Part I	1	23e Did tol	nacco use	contribute to t	he cause of death?	
rds,	w requires that the been signed by th should be detache	ed by	Faith, other significant conditions con	moduling to dealth but not re	Sutting in the c					s 2 🗆 N		/	
Vital Record	aw is b	Completed							24a. Was a	٧	prior to co	ppsy findings available impletion of cause of	
I	Th ate pag	Соп							perform 1 Tes	ned? 2 2 No	death? 1 🗌 Yes	2 No	
VII 8	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital: 🥳	7		Othor		(Check only on				
ö	Phys ar this aral di	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?		me 5 Reside			(y)	
ol	Attending I death. ctor: After y the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accidentinvestigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐	No					
Division		Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of tnjury - At building, etc. (Spec	nome, farm, st ify)	reet, factory, o	ffice		28f. Location (Si City or Town		lumber or Run	al Route Number,	
	Hospital or, 24 hours after Funeral Directed of the feter of the directed of the feter of the directed of the directed of the feter of the directed o	edica C		ician: To the best of my kr er: On the basis of examinand manner stated.									
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon										
			y Code	<i>11</i>) 465	61		JAN	, 11,	2004	
1	4.24		30. Name and address of person who co	mpleted cause of death (Ite	1	M M	An In	2000	3112	1000	51 6	7/3	
(31. Date filed (Month, Day, Year)	32. Registrar's Sign	CAOF 1	in Ko		1001	White	an(a)	0.1	473	
	Sta Registr		JAN 1 3 200	14 1	A. A.	really							

		1 - For Registrar	State of	Marylan		artmen rtificat			and M	lental Hyg	jiene 10g. No.	200		02212
		1. Decedent's Name (First, Middle, Las	t)					_		2. Date of Dea Month	th Day	Yea		Time of Death
Physic /Med		Harold Preston	Ambros							Januar	TI.	8 20		5,20 AM
Exam		4a. Fecility Name (If not institution, give		ber)				Location o			4c.	County of D		
		9818 Sharpsburg		Ann //n um	la a thirth day	If Under		rstow If Under:		8 Date of Birth			ingto	(State or Foreign
Funera		5. Social Security Number 6. S	XM 2□F	. Age (<i>In yr</i> s. : 63	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Apr. 27,	, Year) 194()	Country)	ry land
Directo		219-36-4189 Usual Residence of Decedent						1		,				<i>j</i> . u u
land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation								nside City Limits
Man,	ţ	Maryland Washi	ngton			Hager	stow	n					1	1 □ Yes 2√XNo
h the	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of What	Country?	
h with	a D	9818 Sharpsburg	Pike					1740				US		
deed sm.	Funerai	11. Marital Status	12. Was Deced	067	.S. 13.	Was Dece If Yes, spe	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		 Race - A Bleck, W 		ndian,
or the	F	1 ☐ Never Married 2 ☐ Married	1 XYes 2 If Yes, Give	10	28-	1 🗆 Yes		Specify:				Specify:	1.16	nite
urai',	d by	3 Widowed 4 Divorced	Year or Dat	es: 190		dente bless	-1 0				165 K	ind of Busine		
nat net	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usu kind of wo DO NOT u	rk done a	during mos	t of work	ing	100. KI	ind of Busine	33/11/00511	y
Mathir Mathir	E G	Elementary/Secondary (0·12)	College (1-	4or 5+)			stal					Ph	ones	
Hygie ther	ပိ	17. Father's Name (First, Middle, Last,							er's Nam	e (First, Middle,	Maiden			
d be shifted o	00		Ambrose					Agn	es	Estella	Sı	ummers		
should Me mark	To	19a. Informant's Name/Relationship (19b. Maili	ng Address	(Street a			al Route Numbe			в, Zip Cod	ie)
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 271e marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Muulcal Examican must be rotified at		Martha M. Ambro	ose - Wi	fe	9818	Shar	nsbu	ra Pi	ke	Hagerst	own.	Maryl	and	21740
Hear tem other	1	20a. Method of Disposition		20b. F	Place of Disponentery, cre	osition (Na.	me of			Date	20c. Lo	cation - City	or Town,	State
ages ant of tt: If i	1	1 🖾 Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif		tate		,			lan.1	2,2004	Hane	rstow	n Mar	vland
nit. F artme ortan	ń	21. Signature of Funeyal Service Lices		1 Deal						ne, P.A.	i lug		1,1,0	21795
Depa Depa Impo		1 sing 1	6 He							ie St.Wi	His	amsnor	t Mar	
- 3 - %		23a. Part1. Enter the dis wise, or com	plications that ca	used the deat	th. Do not en	ter the mo	de of dying	g, such as	cardiac	or respiratory ar	rest,	and por	App	proximate erval Between
Pil etalas		shock, or heart failure. List only Immediate Cause (Final	one cause on ea	CAT IIITO.	4-1	s L	(. (0 1	1			set and Death
Physiciai /Medica		disease or condition resulting in death)	a. Due to (c	or as a conseq	quence of):	TE		-					3	# Alle Wat
Examine	r													
15	Je.	Sagrentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (c	r as a conseq	juence oi):									
cuted id ansit	Examiner	Cause (Disease or injury	c											
O, exec an ar rial-ti		resulting in death) Last	Due to (d	or as a consec	quence of):									
GOTUS, P.O. BOX DO/OU, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ical		_ d											
rtifica ng ph	Physician/Med	IF FEMALE:												
th ce	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	ome of pregna rth 2 ☐ Feta	aldeath 3	⊒Ectopic p		,				23d. Date of Month	delivery Day	y Year
death or death of the attention	sici	1 ☐ Yes 2 ☐ No	4∏Pregna 9∏Unkno	ant at time of c wn	death 5	Other (s	oecrfy)						,	
ords, r.O requires that the een signed by th hould be detache	Phy	9 ☐ Unknown Part II. Other significent conditions		- th ht dat and	ltine in the .	and orbitals	201120 5111	on in Part I		23e Did to	abacco i	use contribut	e to the ca	ause of death?
igner	۾	Part II. Other significent conditions	onthough to de	atti put not ies	suiting in the t	underlying .	Jause givi	OII III F AICI		1 🗆 Y	,	/] Probably	
x require	Completed										/			
4	pie									24a. Was autop	SV	24b. Were prior deatl	to comple	findings available etion of cause of
Th Th	000									1 Yes	rmed? 22 No		Yes 2□) No
OT VITAI ING Physician: The I this certificate ha	Be	25. Was case referred to medical examiner?	11				T 0#5		e of Dear	th (Check only o	ne)			
Of V Physic this corral dire	ုင	1 □ Yes 2 No			ER/Outpatie			4 14	ursing H			6 Other (S	Specify)	
E grandfleer	Ë	27. Manner of Death		f Injury n, Day Year)	28b. Time of Injury		28c. Injun Worl		1315	28d. Describe h	now inju	ry occurred		
VISION OT Attending Phy ar death. ector: After thi by the funeral of	ertification;	2 Accident investigated		of Indiana At h		M		Yes 2 🗌	INO	28f. Location (5	Stroot ar	ad Number o	r Rural Bo	oute Number
or At fter d fter d in by	E	4 Homicide determined	289. Place	of Injury - At h ng, etc. (Speci	ify)	treet, racto	y, onice			City or Tox	vn. State	9)	ribiai rio	die Names,
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	O	V	nvelcies: T- #-	hast of mult-	owledge des	th occurre	t at the t-	ne date c	nd place	and due to the	causo/o	and manna	r as states	
Hosg 14 ho Fune tely f	edical	29a. Certifier V Certifying P (Check only 2 Medicel Exa		sis of examina										
thin 2 the mple	Med	29b. Signature and title of certifier	and maili		4	29	c. Licens	e number			29d. Da	te signed (M	onth, Day	Year)
					1	min	T	11./	1,1	73		1/2/	011	,
4x		30. Name and address of person who	completed cause	a of death (Ito	m 23a) (Type	Print		JHE) 4			101	77	
St. Ax		Him Landon	M)	1130	OPAI		T.	40	den	stown	1,	MD.	MIL	40 .
	State	31. Date filed (Month, Day, Year)	32. Py	gistrar's Sign	ature		, , /	1 10	9		-/		- 1	
Pogi		คนเล ก ฏ	4UU4 1	Callen	A	Eng. M.	1							

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			For State	State of Ma	ıryland	•	artmen <i>rtificat</i>			ına iv	ientai Hy	rgiene Reg. No. 2	001	0221	3
			Registrar Decedent's Name (First, Middle, Last,)			imoun	0 0, 1			2. Date of D			3. Time of Death	1
Н	Physici		Elwood McLaughlin	Burkholde	r. Jr						Januar	i Ob	200	4 1020 A	М
	/Medic Examin		4a. Fecility Name (If not institution, give		, , ,		4b. City,	Town, or	Location of	f Death	-3/1/- (()	4c. Co	ounty of Dea		
			Washington County	Hospital				erst					hingt		
	Funeral Director		216-14-6155	7. Age IM 2□F	80	st birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bi (Month, D 12/02/	rth ey, Year) 1923	9. Bi	rthplace (State or Forei country) MD	ign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limi	its
	Manyli 4 aho	jo	MD Washingto	on	Will	Liamsp	ort							1 ☐ Yes 2 🔯 N	No
	as or 28a	i Direc	10e. Street and Number 16722 Tammany Mane			1	10f. Zip	1795				10g. Citize USA	n of What C	country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23e or 28e-f ahow any injury or other traumatic avent, the Medical Exact is at rinal the indiffical at ODGs.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:			Was Deced If Yes, spec		ispanic Orig n, Mexican Specify:	jin? (Spe , Puerto	ecify Yes or N Rican, etc.)		Black, Wh	encan Indian, ite, etc. White	
Baltimore, Maryland 21215-0036	hin 72 hou e. en "naturi Medical i	Completed	15. Decedent's Edd (Specify only highest grad		+)	16a. Deced (Give life.				of work	ing		of Busines:		
7	ed wit ygjen ygjen yer th	Соп	11			Brake	eman/G	Cond	uctor				ilroa	.a	
/land	uld be fill Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) Elwood McLaughlin		er, Si				Rebe	cca	Jane W	orthir	ngton		
Man	nd 2 sho alth and I 27 is me ir traume		19a. Informant's Name/Relationship (T) Lorraine E. Burkh		ife I	19b. Mailir 16722	ng Address Tamm	any	and Numbe Manor	Rd.	, Will	iamspo	own, State, Ort, M	Zip Code) D 21795	
nore,	ages 1 a of of Hei t: If Nem y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 '4 ☐ Donation 5 ☐ Other (Specify,		cer	netery, crer	matory or o	ther plac)/2004			r Town, State	
Baltir	permif. P Departme Importen any injur.		21. Signature of Funeral Service Licens		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	22	2. Name an	nd Addres	ss of Facility	Ger	ald N.	Minni	ich Fu	neral Home D 21740	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death.								,,,,,	- Approximate Interval Between	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ENA Due to (or as:	TAGE	of c	have	. 6.	Astre	til	dung	Dr.	2952	Onset and Death	
68760,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as do do do do do do do do do do do do do											
P.O. Box 6	that the death certificate to be by the attending physis detached for use as the b	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	déath 3	⊒Ectopic pr ⊒ Other <i>(sp</i>					23	d. Date of de Month	elivery Day Year	
Ś	Se un eg	by	Part II. Dther significant conditions co	ntributing to death b	ut not result	ting in the u	inderlying o	cause giv	en in Part I.			tobacco use		to the cause of death? Probably 4 Unknow	
of Vital Record	e law has b je 2 sl	Completed									per	s an opsy ormed?	prior to death?	autopsy findings availal o completion of cause o	ble of
ital	sician: Th certificate rector, pag	O	25. Was case referred to medical						26. Place	of Deat	h (Check only			3 2 110	
1	× × ×	To B	examiner?	Hospital: 1 Inpatie	nt 2016	R/Outpatier	nt 3 DO	Oth Oth	er: 4 □ Nu	rsing Ha	me 5□Res	idence 6[□Other (Sp	ecify)	
0 0	ding Ph th. After fh funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry y Year) 2	28b. Time o Injury		28c. Injun Wor	k?		28d. Describe	how injury	occurred		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ury - At hon	ne, farm, sti	M reet, factor		Yes 2 □!	No		(Street and i	Number or F	Rural Route Number,	
Ö	rs affer rs affer ral Dire	Cert	4 Homiciae	building, et	с. (Эреспу)						City of Ti	JWII, State)		-15	2000
	Hospi 24 hou Funei tely fil	edical	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of iner: On the basis of and manner sta	fexamination	rledge, deat on and/or in	h occurred ivestigation	at the tin n, in my o	ne, date an pinion, deal	d place, th occur	and due to the red at the time	e cause(s) ar , date and p	nd manner a lace, and du	as stated. ue to the cause(s)	
	o the ithin 2 o the omple	Mec	,				29	c. Licens	e number			29d. Date	signed (Mor	oth, Day, Year)	
)	⊢ s ⊢ ō		> longandered M.	is			1	20 4	5040)		1-7-	04		
15	Y HEXY		30. Name and address of person who can be filled (Month, Day, Year) JAN 0 8 2	completed cause of d	eath (Item :	23a) (Type,	Print)	on a	4231	orthe)	V Kel	2114	1		
9	\ 		31. Date filed (Month. Day, Year)	32. Projectra	ar's Sionati	100	1 11	3.	(1790	1000	1 1				
	St: Regist	ate rar	JAN 0 8 2	004 A Prose	m 1	1. Pg	odista	V							

		•	For State Registrar	State o	f Marylan		artmen rtificate			and M		giene Reg. No.	201	04	027	2 4
			1. Decedent's Name (First, Middle,	Last)							2. Date of De Month		,		3. Time of	
	Physicia /Medic		Robert Lee Be	ethke							Januai	cy ll̃1	, 2	2°0°04	132	25 M
	Examin		4a. Facility Name (If not institution,			_	4b. City,		Location o	of Death		4c. Co		f Death		
				emorial					ton					lbot		
	Funeral Director		5. Social Security Number 215-50-5090	3. Sex 12 M 2□F	7. Age (In yrs. 54	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir Jan 2	6, Year 194	49 N	9. Birthple Mary T	ce (State o	r Foreign
	pu »	-	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							100	d. Inside Cit	ly Limits
	r 28a-f show	tor	Maryland Talbot	<u> </u>	100.01	y, 10m10120	East	on							1) Yes	
\$	th with the 23a or 28a ust be noti	I Dire	10e. Street and Number 7605 Woodland Dr	rive			10f. Zip	601				10g. Citizer	n of Wh		/?	
ь г. 36	e	y Funeral Director	11. Marital Status 1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	Armed Fo	2 □ No ⁄e		Was Deced If Yes, spec	1	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)			- Americar , White, et Whi	C.	
Robert 21215-0036	72 hours after "natural", or ite	Completed by	15. Decedent's (Specify only highest	Education	4100.	16a. Dece	dent's Usua kind of wor DO NOT us	Il Occupa	ation Juring mos	t of worki	ng	16b. Kind	of Bus	iness/Indu		-
RoJ 2121	filed within Hygiene.	Comp	Elementary/Secondary (0-12)	College (1	I-4or 5+)		ultar							cturi	.ng	
ethke, Maryland	0 0 0 0	To Be (17. Father's Name (First, Middle, L William Albert		Sr.				Jos	seph:	ine Nil	les_				
			19a. Informant's Name/Relationshi Paige Russell I		.fe		-				aston,	-	160:		oġe)	
Baltimore,	iges 1 and in of Health: If item 27 or other tr		20a. Method of Disposition 1 Darial 2 Cremation			Place of Dispo)ate	20c. Local				
it Fi	permit. Page Department Important: I any injury o	1	*4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral State B L	- 4	Mic						14/2004					
Ba	perm Dep imp	8 1	Holled Aus	rate De	mu	Ul 22	d Sho 272 Hu	ore (<u>idsor</u>	irema n Rd.	tion , Ca	Center mbridge	, P.O , MD	21	ox 14 <u>61</u> 3	.64	
760,	Prny and Asicien and Pariat-Iransit e pariat-Iransit	Examiner	23a. Part. Enter the disease of shock, or heart failure: List of shock, or heart failure: List of shock, or heart failure: List of shock or heart failure: List of shock of sh	a. Due to	(or as a conseq	juence of):	Cell	le	ANG	Ce	auch	11631,		la la	Approximate nterval Bety prosent and E	ween
6876	a X a	edical		d												
Division of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certifica sir death. •ctor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregna birth 2 Peta nant at time of d own	aldeath 3□	⊒Ectopic pr ⊒ Other (sp					230	d. Date Monti	of delivery th D		/ear
ds, P	uires that r signed b	by	Part II. Other significent condition	ns contributing to d	eath but not res	sulting in the u	nderlying c	ause give	en in Part I			tobacco use			cause of d	
Recol	The law requirate has been sipage 2 should b	Completed										psy ormed?	/ de	ior to comp ath?	sy findings a	available ause of
tal	i ician: Th certificate rector, pag		25. Was case referred to medical	1					26 Place	of Death	1 Yes		1 [∐Yes 2	□ N0	
>	ysician: is certific director,	o Be	examiner? 1 \(\text{Yes} \) 2 \(\text{Yo} \) No	Hospital:	npatient 2] ER/Outpatier	nt 3 DC	Othe	200		me 5 ☐ Resi		Other	(Specify)		
on of	ding Phys th. : After this funeral di	tlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe		_	1-1- 21		
Divisi	or Attendate after death Director: /	Certification:	3 Suicide 6 Could no determine	ot be 28e. Place	of Injury - At h ing, etc. (Specif	ome, farm, sti fy)	reet, factory	, office		Ī	28f. Location (City or To		vumber	r or Rural I	Route Num	ber,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the ixaminer: On the band man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s) an date and pl	id man	ner as stat nd due to ti	ed. he cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	1	į.		290	. License	number			29d. Date s	signed	(Month, Da	ay, Year)	
	, ,, ,		· A)H	a m				D30	188	7		1/1	2/	04		
_				vho completed caus												
-			Dr. David Smit				East	on, N	1D 2	1601						
	Sta Regist		31. Date filed (Month, Day, Year) JAN 1	3 2004	gistrar's Signa	A A	Carl	,								

Baughman, Howard J

	•	- For	artment of Health and Mental Hygiene ortificate of Death Reg. No. 2004 022	215
Physicia	n	Decedent's Name (First, Middle, Last) Howard James Baughman, II	2. Date of Death Month Day Year	
/Medica Examine	_	4a. Facility Name (If not institution, give street and number) North Arundel Hospital	4b. City, Town, or Location of Death 6160 BUCNIE Ac. County of Death And And And And And And And And And And	de/
Funeral Director		5. Social Security Number 6. Sex 7. Âge (In yrs. last birthday 220-56-9136 1 № 2□ F 52 Yrs.		r Foreign
faryland show		Usual Residence of Decedent 10a. State 10b. County MD Anne Arundel 10c. City, Town or I	ocation 10d. Inside Cit Severna Park 1 □ Yes	-
vith the M t or 28a-f	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantant if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I	613 Center Drive 11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2□ No Specify: Specify: White	
Maryland 21215-0036 at 2 should be filed within 72 hours aft It and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Examples.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use relired) ity Control Inspector Defense Contract	or
and 21 d be filed w sintal Hygier ced other th	Be	17. Father's Name (First, Middle, Last) Howard James Baughman, Sr.	18. Mother's Name (First, Middle, Maiden Sumame) Jane Elizabeth Pucciarella	.01
Maryl nd 2 shoul th and Me 27 is mark traumati	ဥ	1 121 1	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Center Driver, Severna Park, MD 21146	
altimore, mit. Pages 1 ar partment of Hea portant: If Item: y injury or othe		1 Burial 2 XCremation 3 Hemoval from State	osition (Name of ematory or other place) Date 20c. Location - City or Town, State Baltimore, MD 2004	
Balti permit. Departm imports any inju once.		A CONTRACTOR OF THE CONTRACTOR	Name and Address of Facility Sarranco & Sons, P.A. Severna Park Funeral 195 Gov. Ritchie Hwy, Severna Park, MD 211	Home 46
eale be executed with physician and physician and the burial-transit	Examiner	23a. Party Enter the disease, or complications that caused the death. Do not eshock, or heer failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Understanding Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	spiratory failure Onset and C	
9 = 5 8	by Physician/Medical		□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day	Y ear
rds, P.	d by Ph	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of d	
Records The law require ate has been sig	Completed	diobets wellitus type 2	24a. Was an autopsy findings autopsy performed? death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No	available ause of
Afte fune	To Be	25. Was case referred to medical examiner? 1 Yes	of 28c. Injury at 28d. Describe how injury occurred	
Division To the Hospitel or Attending within 24 hours after death To the Funerel Director: After completely filled in by the fune	Certification;	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		ber,
the Hospi hin 24 hour the Funer npletely fill	Medical	(Check only 2 Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 29c. License number 29d. Date signed (Month, Day, Year)	s)
To wit To	-	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type	Dro58719 January 12, 200	4
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	spital Drive Flen Burnie Maryland 210	143

			. FUI	Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 0221	6				
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JAMES PURNELL	11 20 1 0 1	M				
1	Examin	er	4a. Fecility Name (If not institution, give street and number) 19 Cypress Rd.	4b. City, Town, or Location of Death Annapolis Anne Arundel					
Ī	Funeral Director		5. Social Security Number 212-30-6061 6. Sex $1 \ M$ M $2 \ G$ F 7. Age (In yrs. last birth $2 \ T$ Y		חק				
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland the Hallh and Mental Hygiene. ten 27 is marked other than "natural", or flems 23e or 28e-1 show other treumatic event. The Medical Examinar must be notified at	h the Maryland r 28a-t show	irector	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Anne Arundel Harwoo 10e. Street and Number	1 Mayes 2 □ No. 10f. Zip Code 10g. Citizen of What Country?					
	Completed by Funeral Director	4336 Muddy Creek Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? Warves 2 No If Yes, Give Year or Dates 1952-54	USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2♥ No Specify: 1□ Specify: Black						
	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Onstruction Self Employed						
	uld be filed Mental Hyg srked othe	To Be C	17. Father's Name (First, Middle, Last) James E. Blake	18. Mother's Name (First, Middle, Maiden Sumame) Gertrude Smith					
	nd 2 shallth and 27 is m	1 4	James Blake Jr.(Son) 757	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Matchpointe Arnold, Md. 21012					
Baltimore,	permit. Pages 1 are Department of Heal Importent: If Item: any injury or other once.		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	Disposition (Name of ye, crematory or other place) Date 20c. Location - City or Town, State ye, crematory or other place) Date 20c. Location - City or Town, State ye, crematory or other place) Date 20c. Location - City or Town, State ye, crematory or other place)					
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401						
Division of Vital Records, P.O. Box 68760, or attending Physicien: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	licai Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions of the conditions) Due to (or as a consequence of the conditions) Du	Interval Batween Onset and Death 4 VEACS of):	P					
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)						
	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	n					
	The law recate has been page 2 sho	Completed		24a. Was an autopsy findings available performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No	е				
	Certification; To Be	25. Was case referred to medical examiner? 1	ime of Work? M 28c. Injury at Work? 1 Yes 2 No	ce					
Ο̈́	DIVISIC To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide building, etc. (Specify) 29a. Certifier 1 ☑ Certifying Physicien: To the best of my knowledge,	City or Town, State) death occurred at the time, date and place, and due to the cause(s) end manner as stated.					
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)						
	->-0		30. Name and address of person who completed cause of death (Item 23a) (1	D 54734 1/15/2004 Type, Print)					
	Sta	te	ERICA M SCAVELLA, M.D., 1406 S. 31. Date filed (Month, Day, Year) 32. Registrar's Signature		_				
	Regist		JAN 1 6 2004	Aparts.					

			For State Registrar		State	of Marylar		artment rtificate					giene Reg. No.	2006	. 02	217
	Physici	an	1. Decedent's Name (F	V								Date of De Month	Day	Year		e of Death
	/Medic	al	EUGENE 4a. Facility Name (If not		BLAND	(mbar)		Ab Ciby T	Four or	Location o		JANUAF		200		M q00
	Examir	ier	1515 Duh			nno o ry								,		
	Funeral		5. Social Security Numb		Sex	7. Age (In yrs.			1 Year Days	rsvi If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	een 9. Bi	thplace (State	te or Foreign
	Director		577-09-62 Usual Residence of Dec		12X M 2 □ F	93	Yrs.					Oct 16	19:		aryla	
	lend w #			b. County		10c. Cit	ly, Town or Lo	cation							10d. Insid	e City Limits
	Mary Median	tor	FL. E	revai	cd Cour	nty Me	erritt	: Isl	and						1351	Yes 2 □ No
	or 28	Olre	10e. Street and Number					10f. Zip (•		10g. Citiz	en of What C	ountry?	
	• 23•	rai	310 Arte	emis	_	cedent Ever in U	C 12		2953		aia? (Cna	aitu Vaa ar Na		. S . A .	odcan India	
	fter de	Funeral Director	11. Marital Status 1 ☐ Never Married	28 Marriec	Armed F	orces? 2 📆 No	1					cify Yes or No Rican, etc.)		Black, Wh	te, etc.	,
8	rei'.	ام ا	3 ☐ Widowed 4 ☐		It Yes, G Year or	ive		1 ☐ Yes 2	.⊠ No	Specify:				Specify:	White	
21215-0036	within 72 hours efter death with the Maryland ene. then "naturel", or lleme 23e or 28e-f ehow the Mudical Examinar must be molified at	Completed	15. (Specify o	Decedent's only highest of	Education grade completed)	16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa k done d	ition uring most	t of workir	ng		d of Business	•	
12	withir ene. then	ошо	Elementary/Seconda	ry (0-12)	College	(1-4or 5+)		tron					_	land		е
	Hygir other	Be C	17. Father's Name (Firs	it, Middle, La	st)							(First, Middle,				
<u> a</u>	should be and Mentel marked c	To B	William	A. B1	land					Bea	tric	ce Thr	ift			
Maryland	2 sho send is my		19a. Informant's Name	•			1					l Route Numbe	er, City or	Town, State,	Zip Code)	32953
	s 1 and 2 should be filed within 72 hours efter death with the Marylan f Health and Mantal Hyglens if Health emd Mantal Hyglens them 23 is marked other them "nature!", or items 23e or 28e-f show other treumatic event, the Mardical Examinar must be notified at		Kenneth 20a. Method of Disposit		Land (son)	Place of Dispo	Arte	e of			Merri		sland		
ğ	Peges nent of int: If it		1 ☐ Burial 2 ☑ C	remation 3		State	emetery, crer	natory or oth	her place		1/3/	/04				
Baltimore,	F profi		21. Signature of Lunera			1110							5 GU	rna,	DE.	
ä	Depring Period		A.	\bigcirc		M005	$10 \mid 1$	18 W	a r est	Cro	ss S	ome o	t St lena	epher MD	1 L S 216	chaech 35
	Pnysician /Medical Examiner	Iner	23a. Fart. Enter the dishock, or heart fa shock, or heart fa Immediate Cause (Findisease or caraftion resulting in death) Sequentially list condition and the cause. Enter Underlying Cause, (Disease or injurious).	ilure. List on al ions, diate	a. Due to	each line.	tion juence of):	priem	mor	× × × × × × × × × × × × × × × × × × ×	cardiao	Tospilatory a	1031,		Approxi Interval Onset a	Between nd Death
	The law requires that the death certificate be executed site has been signed by the ettending physician and page 2 should be deteched for use as the buriel-transit	Physician/Medical Examiner	Usease or injunt that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 □ Nc	egnant nths?	d 23c. If yes, or 1∐Live 4∐Preg	tcome of pregnabirth 2 Fets	ancy	Ectopic pre					23	d. Date of de Month	livery Day	Year
P.O.	that the de led by the deteched	hys	9 ☐ Unknown		9□ Unki	nown						_				
ords, I	w requires the been signed should be de	þ	Part II. Other significar	it conditions	contributing to	death but not res	ulting in the u	nderlying ca	iuse give	n in Part I.	-		obacco us /es 2	e contribute t No 3□P	o the cause robably 4	
l Records,	The law rocete hes be pege 2 sh	Completed	H											24b. Were a prior to death? 1 ☐ Yes		ngs available of cause of
of Vital	Physicien: Th this certificate rei director, peg	Be	25. Was case referred examiner?	to medical	Hospital:				Othe	6		(Check only o			ar.da	aughte
	ing After une	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident	☐ Pending investigat	28a. Date (Mo	Inpatient 2 of Injury oth, Day Year)	28b. Time of Injury		Bc. Injury Work	4 📋 NUI	2	ne 5 Resident			eaffy) hi	omë
Division	. 0	Certification;	3 ☐ Suicide 6 4 ☐ Homicide	Could not determine	256. Plac	e of Injury - At he ling, etc. (Specif	ome, farm, str (y)	eet, factory,	office		2	8f. Location (8 City or Tov		Number or R	ural Route N	lumber,
	To the Hospital or within 24 hours efte to the Funeral Discompletely filled in	Medical (29a. Certifier (Check only one)	LCertifying I Medical Ex	Physician: To the aminer: On the and ma	e best of my kno basis of examina nner stated.	owledge, death	n occurred a vestigation, i	it the tim	e, date and inion, deat	d place, a th occurre	nd due to the	cause(s) a date and p	nd manner a lace, and du	s stated. e to the caus	se(s)
	To the within 2 To the I	ž	29b. Signature and title	of certifier					License		7		29d. Date	signed (Mon.		r)
•				1	9	- ME)		カト	517	55		_ \	3/04	,	
			30. Name and address						_				l			
	Sta	te.			Delboy 32.	M D . Resistrar's Signa		Chu	rch	Hi1	1 Ro	l. Che	ster	town,	MD.	21620
9	Registr		J	ANO :	5 2004 32	Red strar's Signa	K .	book								

		For State	State of Marylan	d / Depa	artment of He			6004	02218
-		Registrar 1. Decedent's Name (First, Middle, Last)			tillcate of D	Catr	2. Date of Death	J. No.	3. Time of Death
Physici /Medic	al	JESSE MARIE 4a. Facility Name (If not institution, give s	BLAND		4b. City, Town, or L	ocation of Death	JANUAR	Day Year Y 6 , 200 4c. County of Death	4 4:00p M
Examin	er					sville		Oueen A	
Funeral Director		1515 Duhamell F 5. Social Security Number 6. Sex 201–18–9765		last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 22	0.0:4	nnlace (State or Foreign untry)
and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
Maryla f sho	5	FL Brevard	Me	errit	t Island				1X Yes 2 □ No
death with the Maryland ms 23a or 28a-f show traust be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
death with ms 23a or		310 Artemis Blv	d		32953		Ţ	J.S.A.	
	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
within 72 hours after dea ene. then "natural", or Items he Medical Examiner m	þ	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1		1 ☐ Yes 2X No	Specify:			hite
natu	ete	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion uring most of worki	na	sb. Kind of Business/ aryland	•
within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		o Dispat			ighway A	
filed Hygi sther	ပ္	17. Father's Name (First, Middle, Last)		- Haai		18. Mother's Name			
	To Be	John Brooks				Minnie	Tonoa		
2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type	эө, Print)	19b. Maili	ng Address (Street ar	nd Number or Rura	I Route Number,	City or Town, State, Z	ip Code)
7.2 mg		Kenneth S. Blan							FL. 3295
m O L		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State		osition (Name of matory or other place	i	. 160	oc. Location - City or	
Pag tment tant: jury		' 4 ☐ Donation 5 ☐ Other (Specify)	Ke		emation	1/7/		myrna, D	
permit. Page Department Important: If any injury or		21. Significant of Funeral Service Licenses 23a. Part Enter the disease, or complishock, or year failure. List only or	MOO	510 1	18 West	Cross S	St. Gal	ena, MD.	L Schaec 21635
Physician /Medical Examiner partial physician and physician and physician and the ph	dical Examiner	Immediate Catuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (o	uence of):	urtery	ars 20	150		
Physician: The law requires that the death certifica riths certificate has been signed by the attending phraid director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 型 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
res that thi igned by be detac	ğ	Part II. Other significant conditions cor	ntributing to death but not res		ınderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
w requires t been signe should be	eted	1112111111111					24a. Was an		
sician: The law certificate has t irector, page 2 s	Completed	Hypertens	100				autopsy perform	prior to d	topsy findings available completion of cause of 2 No
ician certifi rector	Be	25. Was case referred to medical examiner?	lospital:	1550:		26. Place of Death			daughte
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	lon: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury Work		me 5 Hesider 28d. Describe hov		home
I or Attending after death. Director: After d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st fy)			28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Ce	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, dea ation and/or in	th occurred at the time	e, date and place, inion, death occurr	and due to the car red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (Monti	n, Day, Year)
7. w 7. o		1 / bail // 1	1/	-	0000	5(8)	/	1/7/04	1
		30. Name and address of person who co	1160	m 23a) (Type		Galar	W MD	21639	<u> </u>
		31. Date filed (Month, Day, Year)	32. Registrar's Signa			Oriego	~	U. V)	-
St: Regist	ate rar	JAN 0 7	2004 Signature	J	Soul				

			1 - For State Registrar	State o	f Marylar	•			lealth a		lental Hy	giene Reg. No	200	1	02219
Ė			Decedent's Name (First, Middle, La.)	st)							2. Date of Dea	ath	-	- 1	3. Time of Death
	Physici		Virginia Goodma	n Babic	ki						Month January	v 2	2004	ar	3:00 A M
	/Medio Examin		4a. Facility Name (If not institution, giv				4b. Cit	y, Town, o	r Location	of Death	Carrace		. County of [Death	J.00 A
	LAGITIII		Chester River M	anor				Char	stert	05.710			V	ent.	
	Funeral		5. Social Security Number 6. S	өх	7. Age (In yrs.	last birthday)		er 1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da	th Vaari			ace (State or Foreign
	Director		220-12-0393	□M 2☐F	92	Yrs.	Month	Days	Hours	Min.	Feb. 1		11 1		vland
۳	ס		Usual Residence of Decedent									1			
	show		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10	d. Inside City Limits
	a Ma	Ş	MD. Kent		Ch	estert	own								1 ☐ Yes 2 ☐ No
	# 52 B	Director	10e. Street and Number				10f. Z	ip Code				10g. Ci	izen of Wha	t Count	ry?
	death with the Maryland ms 23e or 28a-f show rmust be notified at		123 Philosopher	s Terra	ce			2162	20				USA		
	dea	Funerai	11. Marital Status	12. Was Dece	edent Ever in U	J.S. 13.	Was Dec	edent of H	ispanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - A Black, V		
õ	afte or it		1 Never Married 2 Married	1 ☐ Yes If Yes, Gir	24 No		1 ☐ Yes		Specify:				Specify:		
200	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:			21						Whi	
ភ	be filed within 72 hours after death with the Maryla lat Hygiene. d other then "netural", or items 23e or 28e-f shov event, it e Medical Evament must be notified at	Completed	15. Decedent's E (Specify only highest gra			16a. Dece (Give	kind of v	rork done	during mos	t of worki	ing		ind of Busin		•
7	vithin hen.	E D	Elementary/Secondary (0-12)	College (_	_		use retired	•				p and		
V	lled v lygie her t		8th 17. Father's Name (First, Middle, Last,)	S	eams	tress		ar's Name	(First, Middle,		thing	Fac	tory
ב	be fi	Be													
چّ	nark nark	10	William R. Good			10h Maili		an /Chrant	Sac	dia F	Rovenia Al Route Numbe	Fog	well	- 7:- /	2-4-1
Z Z	12 sh h and 7 Is m reum		19a. Informant's Name/Relationship (-							10, <i>ZIP</i> (20 0e)
— თ	s 1 and f Health item 27 other to		Harry Augustine St	nith, J		Place of Dispo	BOX	142	Wort	on,	Marylar Date	od 2	1678 ocation - City	or Toy	vn State
ō	0 0		1 ⊠ Burial 2 ☐ Cremation 3 ☐		State	cemetery, cre	matory or	other plac	1			200. 0	oction on	00.	m, otalo
	t. Pag tment tent: I		'4 □Donation 5 □ Other (Special		Ch	ester				1/5/2	2 <u>004 (</u>	Ches	tertov	m,	Maryland
galt	permit. Departm Importe any inju		21. Signature of Funeral Service Licer	1//	05	Ę	ello	ws, H	ss of Facili Ielfer	ıbeir	& Newr	am	Funera	1 H	ome, P.A. 1620
	40140	L	23a. Part1. Enter the disease, or com		eu e	<u> </u>	30 S	peer	Road	Ches	stertown	1, M	arylar	d 2	1620 Approximate
			shock, or heart failure. List only	one cause on e	ach line.				•						Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Q	ate	ucellin	z try	de	STYLO	. 5	nnolm	re	-		3 days
	/Medical Examiner		Testiting in death)	_		quence of):									2.1
		er	Sequentially list conditions,		or as a consec	augaca of):								4	sagus
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 10	(01 23 2 0011360	querice ory.									
	be executed ician and burial-transif	Examin	that initiated events resulting in death) Last	c	or as a consec	quence of);								-	
00/	cate be executed oblysician and the burial-transit	aiE	L.												
200	requires that the death certificate seen signed by the attending physhould be detached for use as the	dicai		d											
	leath certific attending pl	Physician/Me	IF FEMALE:	23c. If yes, ou	come of pregn	ancy							23d. Date of	deliver	v
ğ	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?		oirth 2 🗀 Feta eant at time of c		Ectopic Other	pregnancy specify)	•				Month		Day Year
j	the d y the ched	isi	1 Yes 2 No 9 Unknown	9□ Unkn				,,,_							
7	n requires that the de been signed by the s should be detached		Part II. Other significant conditions	ontributing to d	eath but not res	sulting in the u	inderlying	cause giv	en in Part I		23e. Did to	obacco	use contribut	e to the	cause of death?
ďs,	uires n sigr	d by	Chronic U	vinary	infre	trans					101	res Ž	No 3] Proba	bly 4 □Unknown
cord		iete	demontio	_ '							24a. Was	an	24b. Were	autop	sy findings available
ě	eicien: The law certificate has b irector, page 2 sl	Completed									autop perfo	rmed?	deat	h?	sy findings available pletion of cause of
VITal	n: Ti	e C	25. Was case referred to medical						20 Diago	of Dooth	1 Yes	2 No	10	Yes 2	2 ∐ No
5	eicie centi	o B	examiner?	Hospital:	npatient 2	ER/Outpatier	nt 3 🗆 [Oth			n <i>(Check only o</i> me 5 ☐ Resid		€ □Othor (Sanaif ()	
ō	Phy r this eral d	⊢	27. Manner of Death		of Injury	28b. Time o		28c. Injun Wor			28d. Describe h			specity)	
0	ding Ih. Afte	ţ	1 Accident 5 ☐ Pending investigatio	1	th, Day Year)	Injury	М		k? Yes 2 🗍	No					
DIVISION	Atter dea ctor	fica	3 ☐ Suicide 6 ☐ Could not b	200. Flace	of Injury - At h	iome, farm, sti	reet, facto	ory, office		- :	28f. Location (S	Street ar	d Number o	r Rural	Route Number,
É	after Dire	Certification:	4 Homicide determined	build	ng, etc. (<i>Speci</i>	ry)					City or Tou	vn, State)		
	spite		29a. Certifier 1 Certifying Pt	ysicien: To the	best of my kno	owledge, deat	h occurre	d at the tin	ne, date an	d place,	and due to the	cause(s	and manne	r as sta	ted.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director,	Medical	(Check only 2 Medicel Example one)	niner: On the b	asis of examina ner stated.	ation and/or in	vestigation	on, in my o	pinion, dea	ith occurr	ed at the time,	date and	d place, and	due to t	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		^			9c. Licens				29d. Da	te signed (M		ay, Year)
				2	W			000	548	90	>	1	1210	4	
			30. Name and address of person who	completed au	e of death (Iter	m 23a) (Type,	Print)								
-2			Dr. Heather Mor	ohv. M.	D. 6602	Churc	h H∹	11 Da	ad C	Thorat	ont -	-36			(00
	Sta		Dr. Heather Mor	32. F	egi dar's Sign	ature 14	Las	A D	,uu , (mest	er comi,	, ma	ryranc	21	020
	Regist	rar	1/AL() (1 ZUU4	A STATE OF THE STA	1	15 150	100							

Northampton Manor Health Care Center Freder Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	2. Date of I Month Janua	Day Year	3. Time of Death									
Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, Northampton Manor Health Care Center Freder 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	Janua	0 0000										
Northampton Manor Health Care Center Freder Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		ry 9 2004	1:15 PM									
	or Location of Death	4c. County of Death										
Director 217-28-7961 1 M 2X F 91 Yrs.	s Hours Min. (Month, I	Frederick Birth 9. Birthple Count 9, 1912 Mary	ace (State or Foreign lry)									
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10	d. Inside City Limits									
Maryland Montgomery Clarksburg			1 ☐ Yes 2x No									
Maryland Montgomery Clarksburg 10e. Street and Number 10f. Zip Code		10g. Citizen of What Count	ry?									
23905 Clarksburg Road 20	871	U.S.A.										
23905 Clarksburg Road 20 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 20 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Towno	Hispanic Origin? (Specify Yes or Noban, Mexican, Puerto Rican, etc.)											
1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No		Specify:	ю.									
Theorem Married 2 Married 1 Tyes 2 Tyles 2 Tyl		Whit										
To a state to be completed by the state of t	e during most of working	16b. Kind of Business/Ind	•									
Cafeteria M.		Montgomery C School Syste	-									
O POR LE CATELETTA M. 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle		111									
Thurston B. King	Pomona Bur	dette										
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree	et and Number or Rural Route Num											
≥ ຮູ້ຮູ້ E. Allan Burdette - Son 23300 Shilo	h Church Road, E	Boyds, Marylan	d 20841									
	(ace) Date	20c. Location - City or Tow	m, State									
*4 Donation 5 Other (Specify) Hyattstown Method		04 Hyattstown	, Maryland									
m issess Nover / Nellanna	olesworth P.A., ee Road, Damascu	s Maryland	20872-0117									
The state of the s		Interval Batween Onset and Death										
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 Y	су	23d. Date of delivery Month E	y Day Year									
S S S S S S S S S S S S S S S S S S S	- _	tobacco use contribute to the	cause of death?									
The law requirements of the la	24a. Wa		sy findings available pletion of cause of									
	peri 1 ☐ Yes	formed? death?										
We see the second of the secon	26. Place of Death (Check only	one)										
L 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury Wo	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify)											
28c. Injury 28d. Date of Inju	28f. Location City or To	(Street and Number or Rural i own, State)	Route Number,									
ON 1 29a. Certifier 29b. Signature and little of certifier 29c. Licentifier 29c.	time, date and place, and due to the opinion, death occurred at the time	, date and place, and due to t	he cause(s)									
and manner stated. 29c. Licens 29c. Licens	se number	29d. Date signed (Month, Da	ay, Year)									
	16428	1/12/0	4									
30. Name and address of person who completed cause of death (Itel 23a) (Type, Print)		, , , , , , , , ,	l									
Casper E. Cline III, M.D. 300 West 9th Stre	et, Frederick, N	Maryland 2170	1									

			1 - For State Registrar	State of M	larylan		rtment of t	lealth and M Death		jiene _{eg. No.} 20	104	02221
	Physici		Decedent's Name (First, Middle, I JOSEPH ROBE)		}				2. Date of Deal Month JANUARY		Year	3. Time of Death 10:10AMM
	/Medic Examin		4a. Facility Name (If not institution, g)		•	r Location of Death		4c. County	of Death	
	Funeral Director				ge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthp	lace (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	eation				11	0d. Inside City Limits
	Ba-1 sh	Director	MARYLAND CARI	ROLL		WESTMI	_					1 X Yes 2 □ No
	Marth the same of Same or Same		10e. Street and Number 374 WINGED FOOT	DRIVE			10f. Zip Code 2115	58		Og. Citizen of WUNITED		•
2	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, It's Moulcal Examinations to colline and	y Funeral	11. Marital Status 1 □ Never Married 2 → Married	12. Was Deceden Armed Forces 1	? No	lf 1	Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Dican, etc.)		e - America k, White, e	etc.
2-002	72 hours natural', dical Ex	eted by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest)	Year or Dates Education	1955	16a. Deced	ent's Usual Occup	pation during most of work	king	16b. Kind of Bu	WIT.	ITE dustry
717	within jiene r than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use retire	a) ENGINEER		DEPT C	F AGI	RICULTURE
2	be filed stal Hygid od other event, II	Be	17. Father's Name (First, Middle, La						ne (First, Middle, I		е)	
3	2 should be and Mental Is marked sumatic ev	2	WALTER CARL BIN 19a. Informant's Name/Relationship			19b. Mailin	g Address (Street	and Number or Rus			State, Zip	Code)
ž Š	and 2 fealth a m 27 Is har trai		GAIL C. BINDER/	WIFE	20h E		WINGED FO	OOT DRIVE				21158
	Pages 1 nent of H int: If ite iry or of		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		,	emetery, crem	atory or other pla			20c. Location - HAMPSTE		WARYLAND
	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Lic	1 July		- M	Name and Addre	ss of Facility BORAW FUN S STREET,	ERAL HOM	E, P.A.		21157
,00,00	icate be executed XMedical Shapes in the burial-transit	dical Examiner	23a. Part1 Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Lisease or injury that initiated events resulting in death) Last	ly one cause on each	line. O r s a conseq s a conseq	etal uence of): uence of):	or the mode of dyin	=	or respiratory arre	est,		Approximate Interval Batween Onset and Death
.O. DOA	the death certifity the attending y the attending sched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	! death 3 □	Ectopic pregnancy Other (specify)	/		23d. Date Mor	e of deliver	ry Day Year
, colda, r	quires that n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death	but not res	ulting in the un	derlying cause giv	en in Part I.				e cause of death? ably 4 □Unknown
ביים ביים	The law recate has bee page 2 sho	Completed							24a. Was as autops perform	y p ned? d	Vere autoprior to com eath?	esy findings available apletion of cause of
SION OF VIEW	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours atted death. within 24 hours atted death. To the Funeural Director After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat			ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing Ho	th (Check only only only only only only only only	ence 6 Othe)
Š	pital or Att urs after de aral Diract	Certification;	3 Suicide 6 Could not determine	building, e	tc. (Specif	v) 	et, factory, office		28f. Location (Str. City or Town	, State)		
	ha Hos n 24 ho he Fune	edical	29a. Certifier 1 ★ Certifying 1	Physician: To the bes aminer: On the basis and manner s	of examina	tion and/or inv	estigation, in my o	ne, date and place, pinion, death occur	and due to the ca	ause(s) and mar ate and place, a	nner as sta ind due to	ated. the cause(s)
		ž	29b. Signature and title of certifier	Allan B	lin	-NO	29c. Licens	e number	29	9d. Date signed	(Month, E	Say, Year)
	NIL		30. Name and address of person when the state of the stat	o completed cause of	death (Item	23a) (Type, F	Print)		1 5 //		./	1 1
	Sta		31. Date filed (Month, Day, Year)	32. Regis	MS par's Signa	iture	SONTU 6	LEENS 7	t., Belti	MOIR,	Mer	ykud 2120)
	Registr	ar	IANIO	5 2004	0.0	10	1					

Amended Item 26 per Physician 01/13/2004 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Richard C. Buffington January 07 2004 2:40 pM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster 1663 Exeter Road Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 18 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Yrs Director 217-36-4297 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits - Bhow r than "netural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at MD Carroll Westminster 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 411 Springdale Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 反 No White Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Southern States 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "in any injury or other traumatic event, the Medions. Elementary/Secondary (0-12) College (1-4or 5+) Carroll Petroleum 11 Truck Driver/Dispatcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emory R. Buffington Carrie Z. Crabs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Immler/daughter 2040 Old Westminster Pike Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Parial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. Paul Cemetery 1/10/2004 Uniontown, MD 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. <. 412 Washington Road Westminster, MD 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset-and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical the the use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Friend's Other: 4 Nursing Home 5 Nother (Specify) Residence ٩ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number NJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 th Coutar Street Westmister, m Dalls Flavio Krutacimo 5555cu 32. Registar's Signature 31. Date filed (Month, Day, Year) State Elsen & Spell Registrar

			1 - For State Registrar	State of M	faryland /	•	tment			and Me	_	giene Reg. No.	2001	0222	23
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in the second	Sta Registr		31. Date filed (Month, Day, Year) JAN (32. Regist	rar's Signature	O. A	South	ر							

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	/Media		ERNEST LEROY		NIER				04 04	1
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	Funeral Director		216-16-3229	7. Age (I	n yrs. last birthday) 80 Yrs.	Months Days			9. Birth Cou 923 MAR	plece (State or Foreign intry) YLAND
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	1/0		30. Name and address of person who co		h (Item 23a) (Type,	Print) JAM	Mayla	IAS NEAL	M.D.	
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Important: I any injury o once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens)	Hager	22. Name and 415 E.	d Address	s of Facility	12-04 Minnich d., Hager	Fune	ral Home	
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unerel Dir	cal Certification:	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best	ic. (Specify) of my knowledge	a, death occurred a	t the time	, date and pla	ce, and due to the c	2422(2)		ated.
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,		30. Name and address of person who co	impleted cause of (death (Item 23a)	(Type, Print)	91	f ca	9075) / 11	, 1 1,	1500

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	Physici /Medic		Arthur Joseph	Choura							ay Year 2004	3:23 P M
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ω,	s 1 and f Health item 27 other tr	1 8	20a. Method of Disposition	27 11210	20b. F				Date	-	ocation - City or To	wn State
وَ	⊕ ° <u>+</u>		1 Burial 2 Cremation) State		sition (Name of natory or other place					
	f. Page rtment o rtent: If njury or		4 □ Donation 5 □ Other (S	-	Smi		g Cremato Name and Addres		The second representation of the second		thsburg,	
g n	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service	Cerisee					ICO C I		uneral Ch	
			23a. Part1. Enter the disease, or	complications that	caused the deat						erstown,	Md. 21742 Approximate
			shock, or heart failure. List	only one cause on	each line.	n. Do not ent		y, such as C	0.000	1	2	Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death)	a	Ch/	Once	OSTUC	The	lux	dill	rse	YPGIT
	/Medical Examiner		rooding in odding	Due to	(or as a conseq	uence of):						100
		<u>.</u>	Sequentially list conditions,	b. — Prince to	for as a consec	uonna offi-						
1	nsit ed	oju	cause. Enter Underlying Cause (Disease or injury	<	(in an a name)	asinos cij.						
_	and and II-trar	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):						
09/8	certificate be executed ding physician and use as the burial-transit					•						
δ	cate phys s the	dicai		d								
×	ding se a	/Me	IF FEMALE:	23c. If yes, or	utcome of pregna	ancy					23d. Date of delive	
Š Q	atter for u	hysician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	I death 3	Ectopic pregnancy Other (specify)				Month	Day Year
o]	y the	ysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unki			(3,500,7)					
		۵.	Part II. Other significant condition	ons contributing to	death but not res	ulting in the ur	nderlyjng cause give	n in Part I.	23	e. Did tobacco	use contribute to th	e cause of death?
g Q	requires that een signed b nould be deta	d by	Dans X= 0	Drolan	Carl	00	1 a Dello	Man	(n)	1 ☐ Yes 2	No 3 Prob	ably 4 ⊡Unknown
	been	eted	Tervery ,	10	1 2		· · · · · · · · · · · · · · · · · · ·	COVE		- 146	law up	C 4:
မှ မ	2 23 89	星	y orovar a	Hy d	SCA	2			24	a. Was an autopsy	prior to cor death?	osy findings available inpletion of cause of
	cate ha	ပိ							10	performed? Yes 2 N	o 1 Yes	2□ No
VITA	ysician: is certific director,	Be	25. Was case referred to medica examiner?	Hospital:		-	Othe	Territory 1000	of Death (Chec	-51-51-52		
ō		၉	1 ☐ Yes 2 No 27, Manner of Seath	11		ER/Outpatien 28b. Time of	t 3∐ DOA	4 Nurs	71		6 Other (Specify)
ב	Attending Proystotan: r death. sctor: After this certific by the funeral director.	io.	1 Natural 5 ☐ Pendin		of Injury onth, Day Year)	Injury	Work	rai ⟨? Yes 2. □No	1	scribe how inju	iry occurred	
Si i	death death stor: / the	icat	Accident investig	not be	of Injury . At h	ome farm etr	et, factory, office	165 2 14		eation (Street a	nd Number or Rura	I Pouto Number
Division	or A after Direction by	Certification;	4 Homicide determ	build build	ling, etc. (Specif	y)	eet, ractory, office		City	y or Town, Sta	e)	Houte Number,
_	purs and and and and and and and and and and		29a. Certifier 1 Certifyir	na Physician: To th	e hest of my kno	wiedne death	Occurred at the time	o date and	place, and due	to the cause/	s) and manner as st	atod
-	24 hos 24 hos Fun etely	ledicai	(Check only Medical one)	Exeminer: On the	basis of examina	ition and/or inv	restigation, in my op	pinion, death	occurred at th	e time, date ar	d place, and due to	the cause(s)
	lo the flospilel of Attending Privy within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Me	29b. Signature and title of certifie				29c. License	number		29d. D	ate signed (Month, I	Day, Year)
,	- s ⊢ ó		> //				D	168	06	1	MACO	1200 T
	5		30. Mame and andress of person	who completed cau	ise of death (Item	n 23a) (Tyne	Print)	1	1	-0	7 3	1
b/X			MAD. XIN	フフィフ	NACT	Lon	The H	690	Nou	1 Mr	1>17	42
	Sta	ite	31. Date filed (Month, Day, Year)	7 2004 32.	registrar's Signa	ature /	1. 1/2	100				
3/	Registr		JANU	2004	eners.	N. Pop						

			1 - For State Registrar		Maryland / I	-	artmen rtificate			and M	Re	g. No.	2004	Col hou las has
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Las DWIGH Aa. Facility Name (If not institution, give	T VERNON		, .	4b. City,	Town, or	Location o	of Death	2. Date of Death Month JANUARY	Day 9	Year 2004 County of Death	3. Time of Death 5:12 P M
i	Funeral Director		### GARRETT COUNTY ME 5. Social Security Number		IOSPITAL Age (In yrs. last bil 82	rthday) Yrs.	If Under Months	OAKL 1 Year Days	AND If Under a	Min.	8. Date of Birth (Month, Day, MARCH 31	Year)		place (State or Foreign intry)
	death with the Maryland ms 23e or 28e-f show rinust be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD GARRET	Т	10c. City, Tow		E PARI							10d. Inside City Limits YYes 2 □ No
9-0036	ges 1 and 2 should be filed within 72 hours atter death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23e or 28e-f show or other treumatic event, the Wedeal Examinating the notified at	by Funerai	10e. Street and Number 99 HOLLY LANE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	cation	s? ⊒No s: 1944–46	Dece	1 ☐ Yes 2	2 ent of His ify Cubar	Specify:		cify Yes or No- Rican, etc.)	14 S	USA I. Race - Americal Black, White Epecify: WH	ican Indian, , etc.
Maryland 21215-0036	uld be filed within 73 Mental Hygiene. rked other than "m tic event, the Medi	To Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last) FRANK CLARY	de completed) College (1-4c		(Give life.	kind of wor DO NOT us GNAL I	k done d e retired)	TAINE	R r's Name	ng	B&O	RAILRO	
	Pages 1 and 2 should nent of Health and Men int: If item 27 Is marke iry or other treumatic		19a. Informant's Name/Relationship (7) HELEN TIMMERMAN 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □	CLARY-WI	FE 20b. Place o	99 f Dispo	HOLLY esition (Naminatory or ot	LAN e of her place	E, MT	LA		MD oc. Loca	Town, State, Zip 21550 ation - City or T	own, State
Baltimore,	permit. Pag Department Importent: I eny injury o once.		21. Signature of Tineral Service Licens	Busdo	cR	22 D	Name and	Addres	s of Facility	OME,	P.O. BO	X 24		LAND, MD
8760,	Physician hysician and physician and physician and physician and the physician and phy	licai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or a	as a consequence	of):	lado	ler			~ with	The	otas- cesis	Approximate Interval Between Onset and Death
.O. Box 6	ath certifi ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death at time of death		Ectopic pre Other (spe					230	d. Date of delive	ery Day Year
s, D	w requires that the de been signed by the a should be detached f	Ď	Part II. Other significant conditions co	ntributing to death	but not resulting in	the u	nderlying ca	use give	n in Part I.		1 ☐ Yes	2 🗆 !	No 3□Prob	
Vital Record	ien: The law ntificate has l ctor, page 2 s	Be Completed	25. Was case referred to medical examiner?						26. Place	of Death	24a. Was an autopsy performe 1 Yes 25		prior to co death?	opsy findings available impletion of cause of
Division of V	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	2	27. Manner of Death 1 Natural 5 Pending investigation	lospital: 12 Inpa 28a. Date of In (Month, D	jury 28b. 1	tpatier Fime of njury		c. Injury Work	4 🗀 Nur	2	ne 5 Residence 8d. Describe how			y)
<u>Divi</u>	Hospitel or Att 24 hours after de Funerel Directo stely filled in by to	i Certification:	3 Suicide 6 Could not be determined	building,	njury - At home, fa etc. (Specify)				date and	G	8f. Location (Stre City or Town,	State)		
	To the Hospitel or within 24 hours afte within 24 hours afte To the Funerel Dir. completely filled in It.	Medicai	(Check only one) 2 Medical Exami	ner: On the basis and manner	of examination an	d/or in	estigation,	in my opi	nion, death	h occurre	d at the time, date	and pla	ace, and due to	the cause(s)
			30 Name and address of person who co	ompleted cause of	releath (Item 23a)	Туре,	Print)	//-	صار	le 1	Fres	6	Nex	Land Mi)
	Sta Registr		31. Date filed (Month, Day, Year) JAN 12 2	32. R gis	strar's Signature	la de	bertes			60		V		SULE

şike.	,		For	State of Maryland / De	epartment of He			_	
			1 - For State Registrar		Certificate of D		Reg.	2001	1 02228
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Lasi VIII A M 4e. Fecility Name (If not institution, give	Edward	Coope 4b. City, Town, or L		2. Date of Death Month January	Day Year 1 200 Y 4c. County of Dee	
	Funeral	iei	Memoria/ 5. Social Security Number 6. Se	HOSpital	Eas	ton If Under 24 Hrs.	8. Date of Birth	Talb	ot
e.	Director		216-40-3977 ¹⁸ Usual Residence of Decedent	M 2□F GO Yrs	Months Dave	Hours Min.	(Month, Day, Ye. OC +: 24, 1		thplace (State or Foreign ountry)
	Maryland a-f show	tor	10a. State 10b. County MD Talb	10c. City, Town o	r Location				10d. Inside City Limits
3	h with the t3s or 28s	Funeral Director	10e. Street and Number	ean gateway	10f. Zip Code	673	10g.	Citizen of What Co	ountry?
§ 98	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or flams 23a or 28e-f show other traumatic event, the Medical Examinar must be rediffied at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decemble Ever in U.S. Armed Forces? 1 1979s 2 1 No. 11979s 2 1 No. 11979s 3 1 No. 11979s 2 1 No. 11979s 1 No. 1197	13. Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No- Rican, etc.)	14 Race - Ame Black, Whit	te, etc.
215-0036	in 72 hou n "natural Aedical E	Completed t	15. Decedent's Edu (Specify only highest grad	lication 16a. De (G	ecedent's Usual Occupati ive kind of work done dur le. DO NOT use retired)	on ring most of workin	ng 16b.	Specify 316 Kind of Business/	2CK /Industry
2	filed with Hygiene. other the	e Com	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-40r 5+)	Nanage	r	C	orting (oods
Maryland	2 should be and Mental is marked of sumatic eve	To Be	Charles E 19a. Informant's Name/Relationship (7)		Fley ailing Address (Street and	Ella	Luven	ia C	ooper
	es 1 and 2 s of Health ar f item 27 fs r other trau		Louvenia 20a. Method of Disposition	SMith 300	. 0 . 0	late way	TRAPP	-	. 21673
Baltimore	permit. Page Depertment o Important: If any injury or once.		1 1 1 1 1 1 1 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Ve teran	25 CP.Wetery 22. Name and Address Herry My Full 5 10 VUAS	of Facility Never 1	104 Hi Home, P.	A:	Maryland
	Physician /Medical		23a. Part. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not ne cause on each line. a. Cerebrovascu Due to (or as a consequence of):	A	4 .	respiratory arrest,	Mba:dg	Approximate Interval Between Onset and Death Day 5
4	Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
8760,	eath certificate be executed attending physicien and for use as the buriat-transit	cal	resulting in death) Last	Due to (or as a consequence of):					
P.O. Box 68	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliment	very Day Year
rds, P	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions con Hypertension	ntributing to death but not resulting in the	underlying cause given i	in Part I.			the cause of death?
Il Records,	The law re cate has be page 2 sho	Completed	Diabetes				24a. Was an autopsy performed?	prior to co	topsy findings available completion of cause of
f Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	lospital: 1 XInpatient 2 □ ER/Outpat	Other	6. Place of Death			
Division of	After fune	Certification:	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 \[Yes \]	28 s 2 🗆 No	3d. Describe how inj	ury occurred	
Div	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.		4 Homicide determined 29a. Certifier 1 Certifying Physics	28e. Place of Injury - At home, farm, building, etc. (Specify) sician: To the best of my knowledge, de	eath occurred at the time	data and place, on	Bf. Location (Street a City or Town, Sta	te)	
	To the Howithin 24 h To the Fur completely	ledical	one)	ner: On the basis of examination and/or and manner stated.	investigation, in my opinio	on, death occurred	d at the time, date ar	nd place, and due	stated. to the cause(s)
)	To To Con	Σ	29b. Signature and title of certifier Louish	lyenathon MD	29c. License nu 2 0 5	5749		ate signed (Month,	
			30. Name and address of person who co					<u> </u>	,
	Sta Registr	-	Dr. Lakshmi Vaidya 31. Date filed (Month, Day, Year) IAN 12 20	32. Medistrar's Signature	nington St F	Easton, M	aryland 2	1601	

			Please	Obstant Manuary								
			For State	State of Maryland		irtment of Fi tificate of I			40	04	022	29
			Registrar	-41	- 061	uncate or i	Deatri	2. Date of Death	g. No.		3. Time of Dea	ath
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	/Medic	al	4a. Facility Name (If not institution, give	CORNIS	> V]	4h City Town, or	r Location of Death	J 303 - 31 - 3	4c. County of			
	Examin	er	Memorial				aston		Ta	albo	t	
	Funeral		5. Social Security Number 6. S	ex / 7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)). Birthpla	ce (State or Fo	reign
	Director		215-44-6107	OM 200 58	Yrs.	Months Days	Hours Will.	Jan: 27,	1945		Rylan	
	P		Usual Residence of Decedeni	10c City	, Town or Lo	cation				100	d. Inside City L	imits
	anylar show	2									1 ☐ Yes 2 [/
10	he M	ecto	MD DORG	hester	140	10f, Zip Code	<u> </u>	10	g. Citizen of Wh	al Countr	y?	
R	ath with the Marylar 123a or 28a-f show ust 5e notified at	Funeral Director	4208-Rai	12 - 1 /4'	11	216	42		ile	54		
La	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race	- Americar White, et	n Indian,	
9	affer dea or itams		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	1 ⊡ Yes 2 No		1110411, 010.)	Specify:			
hoda 21215-0036	be filed within 72 hours affer death with the Maryland fall Hygiene. Id other then "natural", or items 23a or 28a-f show event. If a Medical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:				1.	*	3100		
da 15-("natural",	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	den)'s Usual Occup kind of work done DO NOT use retired	pation during most of work d)	ing	6b. Kind of Busi	11622/11100	istry	
250	withir ane. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)			are		Self	EM	ploye	d
		CO	17. Father's Name (First, Middle, Last,)				e (First, Middle, M			1	
an a	should be filed within nd Meníal Hygiene. I marked other than umatic event, II e M	To Be	Roland	Demby			Laura	GeRtR	ude 1	1:+	chell	
Cornish, Faltimore, Maryland			19a. Informant's Name/Relationship (_	and Number or Run					11 2
Corni	and 2 alth a 127 is er tra		Nice C	ORNISH		8 Rails			RIOCK	ME	2.216	4-
or ore	ges 1 g		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	C	emetery, cre	sition (Name of matory or other place	ca)		0c. Localion - C		. 20	
Ë	nif. Pag arfment ortant: f injury o		' 4 ☐ Donation 5 ☐ Other (Special	m MT	,Zio.		ery 1/16		astive			
Balt	permit. Pag Deparfment Important: any injury once.		21. Signature of Funeral Service Lice	nsee of Dlans	.2	Name and Addre	ss of acility Luneral Shington	Home,	P.A.	1 . /	140 01/	<u>, 12</u>
	20 E 8 0		Tikelle	enlications that caused the deat	Do not en	er the mode of dvir	h ingtur	or respiratory arre	st.	- /	Approximate	
			23a. Part Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	· 7	Care	(~)				Interval Betwee	ith
	Physician /Medical		disease or condition resulting in dealh)	Due lo (or as a consequ	NAMO	(1/10					- ma	<u> </u>
	Examiner			D00 10 (01 25 2 0013041	30.100 5.7.							
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_	cate b	dicai	•	d								
9 X	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregna	incy				23d. Date	of deliver	у	
Во	aften for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		∃Ectopic pregnanc; ∃ Other (specify) _	y 		Mont	h [Day Yea	r
Ö	fhe d y fhe iched	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
۳.	w requires that the death certificate been signed by the attending phy should be detached for use as the	by PI	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.		acco use contrit			
ž	quire en sig ould b							1 ☐ Ye	s PENO 3	, Proba	bly 4 Unki	nown
o O	aw re	piet						24a. Was an autopsy	pri	ior to com	sy findings ava pletion of caus	ilable se of
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ita	sian: artifica ctor.	Be (25. Was case referred to medical examiner?		,	0#	26. Place of Dear	th (Check only one)			
Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certificate this certificate has been signed by the attending physral director, page 2 should be detached for use as the	은	1 ☐ Yes 2 ANo	Hospital: 1 ☐ Inpalien 2 28a. Date of Injury	ER/Outpatie	NI 3LI DOA	4 Nursing n	ome 5 Resider)	
Ę.	ling F After funer	ion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □No		, , , , , , , , , , , , , , , , , , , ,			
isic	Attending ir death. ector: Afte by the fune	fical	3 Suicide 6 Could not I	28e. Place of Injury - At he	ome, farm, si	reet, factory, office		28f. Location (Str		r or Rural	Route Number	τ,
Θį	affer affer Dire	Certification;	4 Homicide	building, etc. (Specif	у)			City or Town	Siale)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifying P	hysician: To the best of my kno iminer: On the basis of examina								
	the Ho hin 24 the Fu	Medical	one)	and manner stated.	THO T AT GOT II	oo- Li		20	d Dale signed	(Month C	Jay Vearl	
	To the To the company	Σ	29b. Signature and title of certifier	2000		29c. Licen	e zes	29	o. Date signed	, nonin, D	~~ \/_	
			1 Interest	an	. 00 \ =	War.	9 9 -	-	UNV 7	1	~7	
			30. Name and address of person was	completed cause of death (Item	n 23a) (Type 2 クみ	Collin	Hurle	ock Mc	1216	4	3	
	Sta	ate	31. Dale filed (Month, Day, Year)	0 9 89 Pegislrar's gna	ature	An .	se number 6 38 8		· · · · · · · · · · · · · · · · · · ·			
15	Regist		JAN	The state of the s	ر معینا	T Apple						

		For	State of Maryla				-		
		State Registrar		Cert	tificate of	Death		Reg. No.	14 02236
Physicia	an	1. Decedent's Name (First, Middle, L.		1 \ 1			2. Date of D Month	eath Day Ye	3. Time of Death
/Medic	al	Charles Bra					Janu		
Examin	er	4a. Facility Name (If not institution, gi		Center	0.1	or Location of Death SECTOWN		4c. County of D	
Funeral				. last birthday)	If Under 1 Year		8. Date of B	rth Kent	
Director		217-07-5053 Usual Residence of Decedent	10X1 M 2□F 96	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	Birthplace (State or Foreign Country) Maryland
/land		10a. State 10b. County	10c. C	ity, Town or Loca	ation	-			10d. Inside City Limits
Man a-f sh	ģ	MD Queen	Anne's C	hester	town				1 □Yes 2½∑No
death with the Maryland ms 23a or 28a-f show rnst be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
ath wi	rai	225 Edmore Rd	•		2162	 		U.S.A.	
er des	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or N Rican, etc.)	o- 14. Race - A Black, W	merican Indian, /hite, etc.
ad within 72 hours after death with the Marylan giene. er fren "naturet", or Items 23a or 28a-f show r re Modical Exeminer must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ⊡Yes 2 ∰No If Yes, Give Year or Dates:	1 [□Yes 21☑No	Specify:		Specify:	White
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led w tygier her th	ပ္ပ	10	41	Owner	r - Ope			Grocery	Store
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hould d Mer mark matic	၉	Charles A. Cam 19a. Informant's Name/Relationship		top Mailine	Add (00	Elsie M			
d2s than than 7 is i								er, City or Town, State	19957
permit. Pages 1 an Department of Heal mportant: If item 2 Iny injury or other		Lillie Dian Du 20a. Method of Disposition	rnam (daugh	Place of Disposi	tion (Name of		etery.	Rd Harr 20c. Location - City	ington DE.
ages ant of tr: If it		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special	Removal from State	-	story`or other plac	cy 1/21	104		
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natur eny injury or other traumatic event, the Medical Once.	Ì	21. Signifur of Funeral Service Lice				-	-	Galena,	
Depa Impo eny ir	-		MO	0510 1.	18 West	cross	St. Ga	alena, MI	en L. Schae). 21635
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused the dea one cause on each line.	th. Do not enter	the mode of dyin	ng, such as cardiac	or respiratory a	arrest,	Approximate Interval Between
Enysician		Immediate Cause (Final disease or condition	a. STAPH	SEP 515					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse	1					1.5-1-1
	_	Sequentially list conditions,	b. BICATEN	12 B1	rcu Ito	priorna	117		146-5-12
ted nsit	in in	Sequentially list conditions, fary, loading to included cause. Enter Underlying Cause (Disease or injury that initiated events resulting indextb.) Lact	(A	quones on	C 4-	priorna			1111 20-
execunate and and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conse		7-15112	me-			10000
ite be ysicia ne bur	cail		d						
Physicien: The law requires that the death certifical this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Med	IF FEMALE:							
ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	el death 3 □E	ctopic pregnancy	,		23d. Date of o	delivery Day Year
es that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5 □ 0	Other (specify)			Month	Day 19ai
that the bad by detac	F.	Part II. Other significant conditions	contributing to death but not re-	sulting in the und	lertving cause give	en in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
puires n sign ild be		-			, ,				Probably 4 Unknown
w requir	jete						24a. Was	an 24b Were	autopsy findings available
The la te has age 2	Completed							psy prior t death	o completion of cause of ?
en: tifica tor, p	a	25. Was case referred to medical				26. Place of Death	1 Yes		es 2□ No
ysici is cer direc	ToB	examiner? 1 ☐ Yes 2 ☐ NO	Hospital: 1 Impatient 2	BR/Outpatient	3□ DOA Otho			dence 6 □Other (S	pecify)
ig Ph ter th neral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	y at		how injury occurred	
Attending Ir death. ector: After by the fune	atic	2 Accident investigation	n	,		Yes 2 □ No			
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, stree ify)	t, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying P	hysician: To the best of my kn	owledge, death o	occurred at the tim	ne, date and place,	and due to the	cause(s) and manner	as stated.
the Ho hin 24 t the Fu npletely	Medical	(Check only 2 Medical Exe	miner: On the basis of examination and manner stated.	ation and/or inve	stigation, in my op	pinion, death occurr	ed at the time,	date and place, and d	ue to the cause(s)
To with	-	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	
/1		30 Name and address of account	completed cause of death (the	m 23a) /Tv 2		13724			7
7		30. Name and address of person who John C. Seyn				nastarta	זער או	21620	
Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature			WII, MI	J. ZIDZU	
Registra	-	JAN	29 200 ▶	1100	Shown !	AND THE PROPERTY OF THE PROPER			

	- 1	= State Registrar Unpend Item#23a	•	3/18/20/ml		Death	Mental Hyg		04 0223
hysicia /Medic xamin	al .	1. Decedent's Name (First, Middle, Last) Barbara 4a. Fecility Name (If not institution, give s Memorial Hospital	Jean treet and number)	0.00	Comb 4b. City, Town, or Cumberla	Location of Death		Day Y 23 200 4c. County of	
neral ector		5. Social Security Number 6. Sex 214 - 30 - 9931	7. Age (In yrs. last	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey 06 / 04 / 1	933 M	Birthplace (State or Fore Country) aryland
iffed at	ctor	Usuel Residence of Decedent	,	Town or Loc Cumber					10d. Inside City Lim 1 (☐ Yes 2 ☐ I
d Dama	i Director	10e. Street and Number 300 N. Waverly Te	rrace		10f. Zip Code	502	1	0g. Citizen of Wha	at Country?
d one than natural, of tems 23s of 28s-1 and event. Its Medical Examinations be extilled at	by Funerai		I2. Was Decedent Ever in U.S. Armed Forces? t ☐ Yes 2 MNo If Yes, Give Year or Dates:		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 No		pecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.
Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give k life. D	ent's Usual Occupa ind of work done of O NOT use retired	ation during most of word)	king	16b. Kind of Busin	ness/Industry
vent. In	Be Cor	12 '		Но	memaker	18. Mother's Nam	e (First, Middle, i	Homema Maiden Sumame)	aker
is marked o	To I	Charles 19a. Informant's Name/Relationship (Ty)	Albert		OVES		/irginia	City or Town. Str	Wilson
5 =		William L.B. Combs			• Waverly			-	
tant: If Item 27 is marke jury or other treumstic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		ition (Name of atory or other place	1		20c. Location - Ci	
any injury once.		*4 □ Donation 5 □ Other (Specify) 21. Signatur of Fineral Service License	Cumb		d Cremato				and, MD al Home, P.,
any i		Lat C. S	John)						, MD 21502
bur bur	lical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ance of): anos of):	iii due to u	ap ng ve	II THE CARDOC	ilis	
igned by the attending phys be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	death 3⊡l	Ectopic pregnancy Other (specify)			23d. Date of Month	
n signed by Jid be detac	ρ	Part II. Other significant conditions cor	tributing to death but not result	ting in the un	derlying cause give	en in Part I.	23e. Did to		ute to the cause of death
is been sig 2 should b	Completed			- 10			24a. Was a autops perform	ned? grid	re autopsy findings avail or to completion of cause ath? Yes 2 \(\text{No} \)
cate ha	Be	25. Was case referred to medical saminer? 1 ★ Yes 2 □ No	lospital: 1 Inpatient 2 XE	R/Outpatient	3 DOA Othe	or	th (Check only or	ence 6 Other	(Specify)
irector, page 2	0	27. Manner of Death		28b. Time of Injury	28c. Injury Work	/ at		ow injury occurred	(Openity)
After this certific funeral director,	2	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation					28f. Location (S	reet and Number	
octor: After this certific by the funeral director,	2		28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		City of Town	n, State)	or Rural Route Number,
Funerel Director: After this certificely filled in by the funeral director.	Certification; To	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify) sicien: To the best of my knowner: On the basis of examination and manner stated.	ledge, death	occurred at the tim		City or Town	n, State) ause(s) and mann	er as stated.
After this certific funeral director,	2	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Accident 6 Could not be determined	building, etc. (Specify) sicien: To the best of my knowner: On the basis of examination	ledge, death	occurred at the tim	pinion, death occu	City or Town	n, State) ause(s) and mann	er as stated. d due to the cause(s) Month, Day, Year)

	cm		1 - For Unpended Item#23a,	ate of Maryland 27, Per ME, C828	d/Depa 2/18/0	rtment tillcate	of H	ealth a Death	and M	lental Hy	giene	2004	02	232
	, ≪ Dhuais		Decedent's Name (First, Middle, Last)					_		2. Date of Dea	ıth		3. Time of	Death
	Physici /Medi		Richard	S. Crocke	ett					January	20,	2004	6:43	РМ
	Examir	ner	4a. Facility Name (If not institution, give stree 38788 Sleepy Hollo			-		Location of				ounty of Death t. Mary	₇ 's	
Z Z	Funeral Director		5. Social Security Number 236–64–2186 6. Sex	7. Age (In yrs. In	as <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birti Month, Day 7/1/44	n /, Year)	9. Birth Coul West	olace (State or ntry) Virgin	Foreign 11a
/	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation							I0d. Inside Cit	
	e Maryli Sa-f sho	ctor	Maryland St. Mary's		hanics		9				_		1 Tyes	
	With th	Funeral Director	10e. Street and Number 38788 Sleepy Hollow	Lane		10f. Zip	Code 0659				10g. Citize	n of What Cou	ntry?	
	Jeath The 2:	era		/as Decedent Ever in U.S rmed Forces?	S. 13. V			spanic Orig	gin? (Spe	ecify Yes or No-		Race - Americ	can Indian,	
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, the Medical Erandrer must be routiled at	by Fun	1 Never Married 2 Married 1	rmed Forces? ÄYes 2□NoReti Yes, Give ear or Dates: 1985	red	Yes, spec			, Puerto	ecify Yes or No- Rican, etc.)		Black, White, pecify: Wh	etc.	
2-0	72 hou	sted	15. Decedent's Educatio (Specify only highest grade cor	1	16a. Deced	lent's Usua	l Occupa	tion	of work	na	16b. Kind	of Business/In	dustry	
Maryland 21215-0036	12 should be filed within hand Mental Hygiene. 7 is marked other than "traumatic event, tra Men	Completed		ollege (1-4or 5+)		kind of word OO NOT us am Ar			OI WOIN	, ig	17 - 4 -	1 C		
d 2	Hygie Hygie other		17. Father's Name (First, Middle, Last)		TTOGI	an An			r's Name	(First, Middle,		ral Gov	/ernmen	, L
lan'	And be dental rked c	To Be	Richard Clyde Croc	kett				En	a V.	Snider				
lary	2 should have in man		19a. Informant's Name/Relationship (Type, F	rint)	19b. Mailin	g Address	(Street a	nd Numbe	r or Aura	l Route Numbe	r, City or T	own, State, Zip	Code)	
	l and lealth im 27 her tr		Tracy Teague/Daughter	20h BI	14227	7 Gov€	ernoi	Lee	P.la	ce Uppe				'2
ا ا	Pages 1 nent of H int: If ite		20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	rai il Oili State	ace of Dispos				1 /0 /			tion - City or To		
Baltimore,	그분원증		* 4 □ Donation /5 □ Other (Specify) 21. Signature ■ uneral Service Licensee	Kal	as Cre	emator . Name and	y d Address	of Facility	1/24 / Geo	/04 . P. Ka	Edgew las F	ater,Ma uneral	aryland Home	
ä	Depa Impo any ir		ANG, Kalas	2.//	61	.60 Ox	on F	Hill .	Rd.	Oxon Hi	11, M	D. 2074	5	
	Physician		23a. Part le Enter the disease ∫or complication shock, or heart failure. List only one ca Immediate Cause (Final	ns that caused the death use on each line. Atheroscleroti						r respiratory arr	est,		Approximate Interval Betw Onset and De	reen
1	/Medical		disease or condition resulting in death)	Due to (or as a consequ		ovascu.	Lar D	Lsease						
4	Examiner	-	Sequentially list conditions, b	Due to (or as a consequ	anno Mi									
	d ' ansit	Examiner	Sequentially list conditions. It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	sae to for as a surpeyo	aries ory.									
8760,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):									
9	tificate ig phys as the	ledic	0											
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and so should be detached for use as the burtal-transit	Physiclan/Medical	in the past 12 months?	yes, outcome of pregnar □Live birth 2 □ Fetal □Pregnant at time of de □ Unknown	death 3 🗌	Ectopic pre Other (spe					230	Date of delive Month	-	ear .
_	uires that signed b	þ	Part II. Other significant conditions contribu	ing to death but not resu	lting in the un	iderlying ca	use givei	n in Part I.			bacco use	contribute to th	ie cause of de ably 4 🗆 Un	
Records,	aw requir as been si 2 should	Completed								24a. Was a	n 2	4b. Were auto	osy findings av	vailable
E R	The ste h	Com								autops perfori 1 X Yes	ńed?		npletion of cau 2□ No	150 OT
Vital	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? You Yes 2 □ No	al:			Other			(Check only on				
of	Phys or this oral di	\vdash	27. Manner of Death 28	a. Date of Injury	R/Outpatient 28b. Time of		lc. Injury Work	4 Nur		ne 5 Reside			at sce	ene
ion	Attending Ir death. sctor: After by the funer	atior	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	М		o es 2□N			,,			
Division	after des Directo	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory,	office		2	8f. Location (St City or Town	reet and N n, State)	umber or Aura	l Route Numbe	91,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physicial (Check only one) 2 Medical Examiner:	n: To the best of my know on the basis of examinati and manner stated.	rledge, death on and/or inv	occurred a estigation,	t the time	o, date and nion, deat	place, a	and due to the ca	ause(s) and ate and pla	d manner as st ice, and due to	ated. the cause(s)	
	To the To the Comp	×	29b. Signature and title of certifier			29c.	License			2	9d. Date s	gned (Month, I	Day, Year)	
			Jashong thee	aber M	0		O.C.	M.E.			Janua	ry 21,	2004	
			30. Name and address of person who comple	110		,	n Sti	reet.	Bal	timore,	Mary	land 2	1201	
4	Sta	te	31. Date filed (Month, Day, Year)	32. Flegistrar's Signatu	ıre				~~~	···········	· narry	THE Z	FCAT	
8	Registr	4 6	JAN 2 9 20	14 Jana Maria	Di.	- C 304	S. P.							

			1 - For State Registrar	State of Maryland		artment of H			giene	004	02	233
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of	f Death
	Physici /Medic		NORWOOD	LOUIS DELK	ER,	SR.		JAN.	5, 20	0 4	7:09	РМ
è	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of D	eath	4c. Count	y of Death		
			CARROLL HOSPITA	L CENTER		WESTMI			CAR	ROLL		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la 1 2□F 7.	* * *	If Under 1 Year Months Days	If Under 24 I Hours N	fin. 8. Date of Birt (Month, Day 1 / 5 / 1 S	h y, Year)	9. Birth	place (State ontry) YLAND	or Foreign
	Director		219-10-0623	78	Yrs.			1/5/19	126	MAR	YLAND	
	land		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside Ci	ity Limits
	Man,	ţo	MD. CARROLL	WE	STMI	NSTER					1 ☐ Yes	2₹ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	death with the Maryland ims 23a or 28e-f show rimust be rotified at		3807 BAKER RD.			2115	57		USA			
92	be filed within 72 hours after death with the Marylan dal Hygiane. dather than "natural", or liems 23a or 28e-f show evant, the Medical Examiner must be rediffed at	by Funeral	1 ☐ Never Married 2 🔀 Married	. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 ☐ No If Yes, Give			ispanic Origin? in, Mexican, Pu Specify:	' (Specify Yes or No- uerto Rican, etc.)		ce - Americk, White,		
5-0036	hour:	p p	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa	Year or Dates: WWII	16a Daga	ient's Usual Occupa	ntion	1				
5	in 72 i •nal	Completed	(Specify only highest grade of	completed)	(Give	kind of work done o DO NOT use retired	during most of	working	16b. Kind of E	susiness/in	dustry	
212	iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		MANAGE	•		TELEPH	ONE	CO.	
פַ	e filed Il Hygi other vant, I	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle,				
<u>Jar</u>	should be ind Mental s marked o umatic eva	70 E	CHARLES	ALBERT DELE	KER		MARY	MAY BO	LLINGE	R		
∺	and and is m	1 2	19a. Informant's Name/Relationship (Type			T 171		Rural Route Numbe	•			
	5 = N L		JOAN M. DELKER	- WIFE		BAKER . sition (Name of	RD., V	VESTMINS'				
Baltimore,	Setien		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer	noval from State	metery, crer	natory or other plac		Date / 7 / 0 4	20c. Location			
┋	it. Päg irtment irtant: h njury o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Secreta Licensee			Y CREMA			SYKESV			1
Ba	permit. Päg Department Important: It any injury o		21. Signature 11 Partial Street Liberisee					FLETCHER ., WESTM				57
			23a. Part . Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. cause on each line.	Do not ent	er the mode of dying	g, such as card	diac or respiratory ar	rest,		Approximate Interval Bett Onset and I	e ween Death
E	Physician /Medical	Ø. 7	Immediate Cause (Final disease or condition resulting in death)	AS	The same of the sa	10le					5 mi	r
Н	Examiner			Due to (or as a conseque		4. 0		VASCULA	. A -		100	- 1
		jer	Sequentially list conditions, b. any, leading to immediate	Due to (or as a conseque	ence of).	116 6	3000	UM COU	17(7	ALV.	10 9	-
	be executed sician and burial-transit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
Ö,	cate be executed bhysician and the burial-transif	I Ex	resulting in death) Last	Due to (or as a conseque	ence of):							
	the the	dlcal	d. :									
ox e	leath certific attending p	/Me	IF FEMALE: 23c	. If yes, outcome of pregnan	cv				and De	to of dollar		
g	atten atten I for u	clan	in the past 12 months?	1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			1	ite of delive onth	,	Year
o.	that the de led by the a detached t	hysi	1	9□ Unknown								
Vital Records, P.	sign sign d be	d by Physiclan/Me	Part II. Other significant conditions contri	buting to death but not result	ting in the u	nderlying cause give	en in Part I.		bacco use con es 2□No	tribute to th		leath? Jnknown
Ö	s been s should	Completed						24a. Was a	an 24b.	Were auto	psy findings a	available
He	The lay	mo						 autop perfor 1 ☐ Yes 	med! 2 No	prior to con death? 1 Yes	psy findings ampletion of ca	ause of
Ita	sicien: The certificate ha rector, page	Be C	25. Was case referred to medical examiner?				26. Place of I	Death (Check only or			20110	
<u>></u>	Physic this ce al dire	户	1 ☐ Yes 2 👿 No		R/Outpatien	t 3 DOA Othe	er: 4 ☐ Nursin	g Home 5 ☐ Resid	ence 6 🗆 Oth	ner (Specif	y)	
Division of	ittending P death. ctor: After t y the funera	Certification;	2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at (? Yes 2 □ No	28d. Describe h	ow injury occur	red		
DIVI	al or Atte s after de il Diracte ed in by th	Sertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specily)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	oer or Rura	l Route Numi	ber,
	To the Hospital or Attending Physicien: white 24 hours after deals. To the Funeral Director: After this certification the funeral director, to the funeral director, to the funeral director.	Medical (29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my know r: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and pla pinion, death o	ace, and due to the occurred at the time, o	ause(s) and malate and place,	anner as st	ated. the cause(s))
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signe	d (Month,	Day, Year)	
)	MIA		· CC.	M	-	Λ	367	-76	1.1	2 . 0	4	
	かナノノハ		30. Name and address of person who com	leted couse of death (Item 2	23a) (Type,	Print)	1	1	~ 6	Ses	Stmin	rel
	9.		Charles C	morning	416) woll	Olm	1 776.16	V V	wo	3118	57
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 3 20	32. Registrar's Stanatu	H	down.						

		1	For State Registrar		eartment of Health and Nertificate of Death		ene 2004	02234
			. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia		ELONI	A DAVI		JANUAR		0602 M
}	/Medic Examin		a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death		4c. County of Death	
	_xam		CHESTER RIVER	HOSPITAL CENTER	CHESTERTO	UN	KENT	/ _
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	rear) Cou	
	Director		215-36-0882	M 2□ F 70 Yrs.		July 24,	1933Unknot	m
	pc ,	-	Usual Residence of Decedent 10a. State 10b. County	10c. City. Town or I	ocation			10d. Inside City Limits
	anyla shov		Tod. State					1. Yes 2 □ No
	188-1	ecto	Marylan∉ Kent 10e. Street and Number	Rock H	all 10f. Zip Code	100	a. Citizen of What Cou	ntry?
	with t	Funeral Director						
	s 23	eral	5761 Judefine Ave	2. Was Decedent Ever in U.S. 13	21661 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ameri	can Indian,
	ter de	Š	11. Marital Status Unknown 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
36	Irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: Unknown	1 ☐ Yes 2 12 No Specify:		Specify:	Black
5-003	filed within 72 hours after death with the Maryland Hygiene. Hysier then "neturel; or items 23e or 28a-f show ent, the Modical Examinar must be multified a	ed -	15. Decedent's Educa	ation 16a. Dec	redent's Usual Occupation we kind of work done during most of work		6b. Kind of Business/Ir	
72	7 oir n n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	ang		
2121	d with	Completed	Unknown		erman		Seafood	
Ď	be filed within 72 hours after death with the Marylan half tyglene. ad other than "naturel," or items 23e or 28a-f show other than "naturel," or items 23e or 28a-f show event, the Marical Examinar mast be inclifted at	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
<u> a</u>	ould be Mental arked o	2	Unknown		Unknow			
Maryland	and and ls m	1	19a. Informant's Name/Relationship (Typ	-,,	iling Address (Street and Number or Rui			
	ウモンヤ		Atto Johnson / Fr		5 Crosby Rd., Rock		aryland 216	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Re	comotony ci	rematory or other place)		•	
<u>Ĕ</u>	Pages ment of i ent: If its ury or o		4 □ Donation 5 □ Other (Specify)	Capitol		/2004 Do	over, Delay	vare
ä	permit. Departi Import eny inj		21. Signature of Funeral Service License	1	22. Name and Address of Facility Bennie Smith Fu	neral Hom	ne	
_	205 2		23a. Part1. Enter the disease, or complic	- / cx L	Bennie Smith Fu Road 298, Chest			Approximate
8760,	death certificate be executed A Medical Example of attending physician and an and an area as the burial-transit	lical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Acretinamin	PANTY		Onset and Death
P.O. Box 68	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delin Month	very Day Year
	taw requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not resulting in the		23e. Did toba	acco use contribute to s 2 □ No 3 □ Pro	the cause of death?
Vital Records,	φ <u></u> <u> </u>	Completed				24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of 2 \(\subseteq\) No
ita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?			th Check onl one		
>	S 5	2	1 ☐ Yes 2 ☑ No H	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	The state of the s		nce 6 ☐Other (Spec	ify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time	y Work?	28d. Describe how	w injury occurred	
Sio	e at	satio	2 Accident investigation		M 1 Tyes 2 No	004 t posting (Cta	and Alumber or Du	ral Bauta Mumbar
Division	or Attendated death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Ru State)	rai noute ivuiliber,
Ω	itel or ral D			1	the state and place	and due to the en	uso(s) and manner as	stated
	To the Hospitel or Atta within 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier Certifying Physical Examination (Check only one)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	TIG INGINIAL STATEGY.	29c. License number	29	d. Date signed (Month	, Day, Year)
	To To		100		D0060301		1/10/04	
			1 unul	Parlated agues of death (than 00=) (T.			.,,	
				mpleted cause of death (Item 23a) (Typ MER W 1245 SEE	en RUSTES CONE	STENTOWN	, med d	1620
		ate	The state of the state of	20 Decistorio Signaturo	0			
	Regist		31. Date filed (Month May, 1eg 200	4 Marin B. A.				

		-	For Unpend Item # 23a	State of Mary ,27,28a-f per	land/Dep me G828-2/ e	artment of 13/04 tas rtificate of	Health and Death	Mental Hygi	ene g. No. 2001	02235
-			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	ysicia Medic		Betsy L.	Dean		,		January	10 2004	1243 p ^M
	camin		4a. Facility Name (If not institution, give s				or Location of Dea	ith	4c. County of Dea	th
79-			815 Stratford I			Fred	erick	S O Date of Birdh	Freder.	
	neral		5. Social Security Number 6. Sex	M 2DE	yrs. last birthday) Yrs.	Months Days		. (Month, Dey,	Yeer) 9. Bir	thplece (State or Foreign puntry)
	ctor	-	218-94-0251 Usual Residence of Decedent	39		11		Nov. 10,	1964 Mai	yrand
yland	4		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
the Marylar 28a-f show	Dauli	ctor	Maryland Frederick		Frederi	lck				1⊠Yes 2 No
or 28	gu a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
ath w	THE STATE OF	ai	815 Stratford Way			217			United	
er de	MET	Funerai	TT. Marias Grands	 Was Decedent Ever Armed Forces? 	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi	
36 Is after	ğ	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
1215-0036 within 72 hours after death with the Maryland ene.	3	ed	15. Decedent's Educ		16a. Dece	dent's Usual Occi	upation	1	6b. Kind of Business	/Industry
215 7 nic 2	Medi	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retir	e during most of wo ed)	orking		
21215-0036 ad within 72 hours aft giene.	2	Completed	12			Homemake	er		Own Ho	me
a High	vent	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M	aiden Sumame)	
Vla Ment Ment	atic	2	Robert M. Dean					1 Rappold		
Baltimore, Maryland 21215-0036 Dermit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.	mar.		19a. Informant's Name/Relationship (Type	·				Rural Route Number,		
e, N l and lealth	hert		Robert M. Dean / F					rederick,	Maryland Oc. Location - City or	
Baltimore, Sermit. Pages 1 a Department of Heam moortant: If item	or of		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval mom state		osition (Name of matory or other pl	Joan	uary 16,		
timer rtant	njury	-	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 			k Cremato			rederick,	
Bal	eny i		21. Signature of Fundam Service License	1				auffer Fur		s, P.A. yladn 21702
-	4841		23a. Part 1. Enter the dise se, or compli	cations that caused the						Approximate
7			shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.			3,	,		Interval Between Onset and Death
Physic /Med			disease or condition resulting in death)	Narcotic Due to (or as a co	intoxicati	-on				
Exam	iner-			240 (0) 43 4 00	naoquence or,.					
- At 1 1		Jer	Sequentially list conditions, if any leading to immediate	Due to for as a con	ns a uence of).					
760, te be executed vsician and	the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
760, te be exe	urial∙t	EX	resulting in death) Last	Due to (or as a co	nsequence of):					
876 ate b	the b	lical		l						
ortifica certifica	for use as th	Physician/Med	IF FEMALE:	2- 16						200
death cert	for us	ian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3[☐Ectopic pregnan☐ Other (specify)	су		23d. Date of de Month	Day Year
. 0 0	detached for	ysic	1 □ Yes 2 □ No 9 ■ Unknown	9□ Unknown	ordeam 5	_ Other (specify)				
T ta b	deta	y Ph	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	inderlying cause g	iven in Part I.	23e. Did toba	acco use contribute to	the cause of daaih?
Records, he law requires to has been signed.	ild be det	d by						1 🗆 Yes	2 No 3 P	obably 4 Unknown
ecord law requ		Completed						24a. Was an	24b. Were at	utopsy findings available
Re la The la ste has	age 2	mo						autopsy		completion of cause of
Vital Pelcian: T	tor. p	0	25. Was case referred to medical			-	26. Place of De	aath (Check only one		20110
of Vita Physician:	funeral director, page 2	ToB	examiner? 1X Yes 2 □ No	ospital: 1 Inpatient	2 ER/Outpatie	ni 3 DOA	ub	Home 5 ☐ Resider		city) at scene
n of ng Physiter this	neral	:u	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury Found Year	28b. Time o	of 28c. Inju	ury at ork?	28d. Describe how	v injury occurred	
Division of or Attending latter death.	the fu	Certification:	2 Accident investigation	1-10-04	unknowr	1]Yes 2. TXNo	Unknown		
or Att	n by	ij	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office	€	28f. Location (Stre City or Town,	et and Nymber of R State) 815 Stra	CTORO Dr.
DIVISIC To the Hospital or Attend within 24 hours after death	completely filled in by	Ce	20. O. Hills.	Home	alessa d'Arrich			Frederick,		
Hospital 24 hours a	itely f	Medicai		sician: To the best of my ser: On the basis of exa						
To the within 2	omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number	29	d. Date signed (Mont	h. Dey, Year)
- X - X - X	ŏ		V/X/J/	04/1/)			OCME		January	
			30. Name and address of person who co	moleted cause of death	(Item 23a) (Type	Print)				
Ü			J. LARON W	KE, MO	(s., 202) (1)po.		enn Stre	et, Baltim	ore, Mary	land 21201
3	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's		As .	Locator			
D	eaistr	ar	.10% 1	5 2nnad 🔎	Radio	100	OF SERVICE STATES			

			1 - For State Registrar	State of N	Marylar		artmen rtificat			ind M	•	gien Reg. N	- 2 H N I	02	236
	<u>.</u>		1. Decedent's Name (First, Middle, L.	ist)							2. Date of De	ath D	av Yeer	3. Time of	Death
	Physicia /Medic		ALMA			DOT	Y				Januar	ry	^{ay} , 2004	4:40	Ам
}	Examin		4a. Fecility Name (If not institution, gi						Location o	f Death		4	c. County of Deeth		
			Frederick Memor:			transitat to 1	Fre	deri	.ck If Under 2	24 Hre	8. Date of Bir	46	Frederic		
l.	Funeral		5. Social Security Number 6. 229-42-4558	Sex 7. A 1 □ M 2 🔀 F		last birthday) 0 Yrs.	Months	Days	Hours	Min.	(Month, De	V. Yee	r) 9. 5. 5. 5. 1913 Nort	plece (State ontry)	1 d n n
	Director		Usual Residence of Decedent		3	,,					Jall. Z	7,	1915 NOT	II Carc	ттпа
	yland		10a. State 10b. County	_		ty, Town or Lo								10d. Inside Ci	ty Limits
	a-f a	ctor	Maryland Freder:	lck	Fr	rederic	k							1 🗌 Yes	2 No
	or 28	Jre.	10e. Street and Number				10f. Zip					10g. C	itizen of Whet Cou	ntry?	
	ath w	Funeral Director	6441 Jefferson P					2170					U.S.A.		
	eb de	nue	11. Marital Status	12. Was Deceder	5?	J.S. 13.	Was Deced II Yes, spec	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White		
36	Ir, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X II Yes, Give Year or Dates			1 🗆 Yes	2 X No	Specify:				Specify:	ite	
ĕ	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f ahow than Marical Examiner mant be motified at	ted	15. Decedent's E			16a. Dece	dent's Usua	al Occupa	ation	and seconds		16b.	Kind of Business/Ir		
215	hin 7	ple	(Specify only highest gi	College (1-40	r 5+)		kind of wo DO NOT u	_))	OF WORK	ng				
7	ed wil	Completed				H	omema	ker					Own Home	2	
Maryland 21215-0036	be fill d off	Be	17. Father's Name (First, Middle, Las								(First, Middle				
<u>\Z</u>	1 Mer narka	P L	Robert Valenti			10h Maili	- Add	(Ctront o			Alexa		or Town, State, Zi,	- Codol	
<u>a</u>	d 2 st th and 7 is r traur		19a. Informant's Name/Relationship Tim Stratton (Sor			1	-						sville, M		/.
	1 an Heal tem 2	37	20a. Method of Disposition	1)	20b. I	Place of Dispo					ate I		Location - City or T		4
ᅙ	Pages nent of int: If it	i	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		Θ	cemetery, crei inteo C				/16/	′0/ı	Mani	teo, Nort	h Cara	line
Baltimore,	그 문문을 .		21. Signature of uperal Service							the state of the same			AL HOMES,		TIIIa
ä	Depa Impo any is		1 Frutex	1 H		1	201 N	ORTH	MARK	ET S	SON FU	EDE	RICK, MD	21701	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	notications that caus	ed the dea									Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	. Ather	LOSC	lerotion	e Ce	? re	bal	Va	Seston	1)/5	ause	Syv	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consec	quence ol):									
	LXAIIIIICI	L	Sequentially list conditions, if any, leading to immediate	b. Due to (or a)	augaga afti									
	led nsit	nine	Cause (Disease or injury	D00 10 (01 2	is a consec	quence on.									
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a consec	quence of):									
760,	ate be executed hysician and the burial-transit	call		d											
89	tificat ng phy as th	_													
Вох	th cer lendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pr	egnancy					23d. Date of deliv Month	-	ear (ear
0	e dea the at ned fo	slci	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknown		death 5	Other (sp	ecity)					MOULT	Day 1	001
ď	Attending Physician: The law requires that the death certifica relath. relath. ector: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the tuneral director.	by Physician/Med	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlyina c	ause cive	n in Part I.		23e. Did t	obacco	use contribute to I	he cause of d	eath?
Vital Records, P	signe d be	d b	0 1	ncer			, , ,				10	Yes :	No 3 Pro	bably 4 🗀 L	Jnknown
Sor	w requir been si should	iete	Aston mas	ù							24a. Was	an	24b. Were aut	onsy findings :	available
Re	hysician: The law his certificate has I I director, page 2 s	Completed	01/20 po.0	to							auto	psy rmed2	prior to co	mpletion of ca	ause of
ta	ician: Th certificate rector, pag	Be C	25. Was case referred to medical	COUTS					26. Place	of Death	1 ☐ Yes	2€ N	o 1 Yes	2LI NO	
	Physici this cer al direc	To B	examiner?	Hospital: 1 ☐ Inpa	itient 2	ER/Outpatier	nt 3 🗆 DO	Othe	er: 4 □ Nui	rsing Ho	me 5 ☐ Resi	dence	6 ☐Other (Speci	fy)	
0	ng Ph Iter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, L	jury Day Yeer)	28b. Time o Injury	f 2	8c. Injury Work	at ?		28d. Describe	how inj	ury occurred		
Sio	tendin eath. or: Aft	cati	2 Accident investigati	he -			М		res 2 🗆 l						
Division of	or At ifter d Direct in by	Certification:	4 Homicide determine	286. Place of	njury - At h etc. <i>(Speci</i>	iome, farm, str fy)	eet, factory	, office		;	City or To		and Number or Run te)	al Route Num	ber,
_	ours a		29a. Certifier 1 Certifying F	hysician: To the be	st of my kn	owledge, deat	h occurred	at the tim	e. date and	d place.	and due to the	cause/	s) and manner as	stated	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 ☐ Medical Ext one)	minar: On the basis and manner	of examina	ation and/or in	vestigation	, in my op	oinion, deat	th occurr	ed at the time,	date a	nd place, and due t	o the cause(s)
	To the within To the Comp	Ĕ	29b. Signature and title of certifier	11		0			number	<i>C.</i>		1	ate signed (Month,	Dey, Year)	
)			Joseph	MIN	u	ort	1	166	60	7		1/2	810-1		
	10		30. Name and address of person who					12	od o===	-1-	Mar 1	۰ د	1702		
	V		Joseph Ashwal, M		as Jo strar's Sign		rive	, rr	euer1	CK,	rarytar	10 Z	1/02		
	Sta Registi			2 2004	Gener	, a	4	do	Du del	./					

Ğ	,033		1 - For State Registrar	State of Ma		id / Depa		of H	ealth a	and M	-		2001	. 02	237
	Physici	an	Decedent's Name (First, Middle, I	Last)							2. Date of De Month	ath Da	y Year		of Death
ı	/Medic Examin		Kendrick A. 4a. Fecility Name (If not institution, g		enni	S	4b. City. 7	Fown, or	Location of	of Death	Janua		4, 2004 County of Dea		0 P ^M
1	LXdiffiii	C1	8350 Revelation						ville				Frederi		
	Funeral Director		5. Social Security Number 6 215-52-2785	150 M 2 F	∍ (In yrs. 55	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Nov. 2(v. Yeer	9. Bi 948 Mar	rthplace (Stell Country)	e or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation								City Limits
	h the Maryland r 28a-f show	tor	Maryland Freder	ick	Wal:	kersvi]	lle								es 2 No
	or 28	Funeral Directo	10e. Street and Number			7	10f. Zip (Code				10g. Ci	tizen of What C	country?	
	eath v	erai	8350 Revalation	Ave.	ever in II	S 13 V	2179		spanic Orio	gin? (Spe	acify Ves or No		ted Sta		
36	172 hours after death with the Maryland "netural", or Items 23a or 28a-1 show idical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ SWidowed 4 ☐ Divorced	Armed Forces?			f Yes, speci 1 Yes 2			n, Puerto	ecify Yes or No Rican, etc.)	,-	Black, Whi	ite, etc.	
215-0036	72 hou	ted	15. Decedent's (Specify only highest of	Education		16a. Deced	ient's Usual	Occupa	tion	e a f a		16b. K	Bla (ind of Business		
7	within 72 ene. than "nei he Wed c	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	kind of work DO NOT use	e retired)		t or work!	ng				
N D	Hyginther ther	S	1 Z 17. Father's Name (First, Middle, La	st)		Supply	Tech			r's Name	(First, Middle,		. Gover	nment	
ומו	ould be Mental parked o	ro Be	Paul Dennis						Helen		Ε.		Den	nis	
Maryland	2 sh and Is n	9	19a. Informant's Name/Relationship			19b. Mailin	g Address				I Route Numb	er, City	or Town, State,		
	s 1 and if Health Item 27 other to		Robert T. James 20a. Method of Disposition	/ Brother	20b. P	lace of Dispo	sition (Nam-	e of			Penns		ania 17		
DE E	8°= 5		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control C		0	emetery, cren ederick	natory or oth	her place	.				-		1
gaitimore,	permit. Pe Departmen Important; any injury once.		21. Signature of Funeral Service Lig		1110							une	lerick, cal Home	maryıa es P.A	and .
n	90 E E 8	1	1 W.B (Teise		16	521 Op	ossi	ımtow	n Pi	ke Fred	erio	ck, Mar	yland :	21702
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	implications that caused by one cause on each lin	the deat								war o	Approxim Interval E Onset an	letween d Death
	/Medical Examiner		resulting in death)	Due to (or as	conseq	uence of):								- CSC U	
A.	De iii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequ	uence of):									
,	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	consequ	uence of):									
8/60,	ate be physicie the bur	cal		d											
ROX PR	certificate nding phys use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of de	livery	
	w requires that the death certifica been signed by the attending ph should be detached for use as it	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pre Other (spe						Month	Day	Year
, T	requires that the een signed by th hould be detache	by	Part II. Other significant conditions	(-		4		use givei	n in Part I.				use contribute to		
coras,	requi	eted	Chun	ic alco	nol	ISM						res 2		robably 4 [
Ē	The larate has	Completed											death?	completion of	s available cause of
VII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No	Hospital:	nt 2 🗆	ER/Outpatien	1 3□ DOA	Other			(Check only o		⊙ ©XOther (Spe		-
ion oi	ding Phys. th. After this of funeral dir	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	у .	28b. Time of Injury		c. Injury Work	at	2	28d. Describe t			icity) AL E	scene
DIVISION	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not 4 Homicide determine		ry - At ho . (Specify	me, farm, stre	eet, factory,	office		2	28f. Location (S City or Tox	Street an vn, State	d Number or Ri	ural Route Nu	ımber,
	e Hospita 24 hours a Funera letely fille	edical (29a. Certifier 1 Certifying Particular Check only 2 Medical Expone)	Physician: To the best of aminer: On the basis of and manner sta	examinal	wledge, death tion and/or inv	occurred at estigation, i	t the time	e, date and nion, deat	d place, a	and due to the o	cause(s)	and manner as I place, and due	s stated. e to the cause	n(s)
	To the To the comp	Me	29b. Signature and title of certifier				29c.	License	number			29d. Da	e signed (Mont	th, Day, Year)	
			Starball	enrus	M	0	1	.C.M	.E.			Ja	nuary 5	5, 2004	
	<i>f</i>		30. Name and address of person we Tasha L Zew		ath (Item	23a) (Type, f		Pen	n Sta	reat	Ral+i	me see	, Mary]	land 21	201
\$ 3 N	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signa	ture	6	-			, Parly	INTE	, racty	Lanu Z	LZUI
AV.	Registr	ar	JAN	1 2 2004	- Park		~	M	ank						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2004 January Robert Lee Davis, Sr. 9:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chester River Manor Chestertown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** t**∑**M 2□F 215-26-4604 Director 82 Mar. 19, 1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYPes 2 □ No Director MD. Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5748 Langford Bay Road 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 TYes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Real Estate Broker Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carolene Bryan ဥ William Enzey Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5748 Langford Bay Road, Chestertown, Maryland 21620 of Disposition (Name of Date 20c. Location - City or Town, State Sammy Lynn Lieupo Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Chester Cemetery 1/8/2004 Chestertown, Maryland L22 Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 21. Signature of Funeral Service Licensee Kick A. The 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** CARDIONUlmmany /Medical resulting in death) Due to (or as a consequence of): **Examiner** Rogressine Supernullean PALSY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attanding Physician: The law requires that the death certificate be executed for use as the burial-transil attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 D Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 123889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 223 1tigh Strut; Chestenton Wed 21420 John C. ARRABAL 31. Date filed (Month, Day 2004 Registar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar	State of M	arylan		artment rtificate			and Me		giene	2004	02239
7	Physici	an	Decedent's Name (First, Middle, I	Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	Chartotte	_ K		can	4b. Çity, T	oum or l	ocation o	of Dooth		12 40 CO	unty of Death	3 30 Fm
	Examin	er	4a. Facility Name (If not institution, g	Joe street and number)	(Caller	1		ocalion o	n Death		And	Ac	
3%	Funeral		5. Social Security Number 6			last birthday)	If Under 1	Year Days	If Under	24 Hrs. Min.	8. Date of Birti (Month, Day	h v. Year)	9. Birthp Cour	place (State or Foreign
	Director		578-38-3033 Usual Residence of Decedent	1□ M 2√2 F	92	Yrs.	Months	Days	Hours	Will.	Oct. 2			TN
	Maryland	tor	MD 10b. County Anne	Arundel	10c. Cit	y, Town or Lo	ocation Annapo	olis					1	0d. Inside City Limits 1 ☐ Yes 3€ No
	with the a or 28a	Direc	10e. Street and Number 1142 Skyway Dri	ve	1		10f. Zip (214	101			10g. Citizen	of What Cour	ntry?
336	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show ovent, I'ra Medical Examinational technical at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?)		Was Decede	ent of His fy Cuban		gin? (Spec i, Puerto P	eify Yes or No- lican, etc.)		Race - Amend Black, White,	
21215-0036	within 72 hou ene. than *natura he Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) Colfege (1-4or	5+)	(Give	dent's Usual kind of work DO NOT use	done du retired)	iring most	t of workin	g	16b. Kind	of Business/In	
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Maryland		To Be	August Sehman K	1.							Molske			
Man	12 sho		19a. Informant's Name/Relationship Richard A. Dunc			1	•				Route Numbe			n, TX 77058
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		20a. Method of Disposition	<u> </u>		Place of Dispo	sition (Name	e of		Da	ite		ion - City or To	
Baltimore,	Pages ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)		etro C				Jan. 2	2004	Balt	imore,	MD
Balt	permit. Pag Department Important: any injury once.		21. Smature of Fire rai a rvice Li	Macco		Ba	2. Name and arrance 95. Gov	:O &	Sons	, P. ?	. Seve	rna Pa	ark Fur	neral Home
	Physician		23a. Pant. Enter the disease, or construction. List or Immediate Cause (Final disease or condition.	omplications that cause only one cause on each I	d the deat ine.									Approximate Interval Between Onset and Death
1760,	Medical Examiner Associate and	cal Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		· d	uence of):	die	pul	Man	7	lisca	a c	-	
.O. Box 68	death certifica e attending ph d for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	□Ectopic pre □ Other (s <i>pe</i>					23d	. Date of delive	ery Day Year
ds, P	uires that signed t	by	Part II. Other significant condition	s contributing to death t	out not res	ulting in the u	inderlying ca	use give	n in Part I.			obacco use res 2 🗆 N		he cause of death?
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed	diasely	,0							24a. Was autop perfor	rmed?	prior to co death?	opsy findings available impletion of cause of
Vital		0	25. Was case referred to medical		/				26. Place	of Death	(Check only o	2⊡ No ne)	1 🗆 Yes	2 No
of	ng Phys fter this	ition: To B	examiner? 1 Yes 2 No 27. Mann: Death Naturaf 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da		ER/Outpaties 28b. Time o Injury		c. Injury Work	4 📋 NU	2	e 5 □ Resid 8d. Describe h			(y)
Division	tal or Attendii s after death. al Director: A ed in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		jury - At he tc. (Specif	ome, farm, st y)	reet, factory,	office		2	8f. Location (S City or Tow		lumber or Rura	al Route Number,
	10 5 E	edical C		Physician: To the best kaminer: On the basis of and manner s	of examina									
	To the Hosi within 24 ho To the Func completely f	Mec	29b. Signature and title of certifie	and mainers			29c.	License	number			29d. Date si	igned (Month,	Day, Year)
			Mhl	Lu, n	4		1	250	392	2		1/4	/Die	
			30. Name and ddress person w	no completed cluse of	death (Item	1	Print)		Anna	polis,	MID ?	2,40	(es = 56	
	Sta Regist		31. Date filed (Month, Day, Year)	2004 32. Regist	rar's Signa	-	hard	p						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM #9 PER FH G828 2/02/04 JH 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Nicholas Dunbar 2004 9:57 January 13, PM /Medical 4b. City, Town, or Locetion of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner 1732 Urby Drive Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) SOUTH CAROLINA
 YOTK 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min. 1⋤M 2□ F 253-46-1482 83 April 12, 1920 Director Usual Residence of Decedent should be filed within 72 hours after death with the Marylend nd Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Funeral Director Maryland Anne Arundel Crofton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1732 Urby Drive 21114 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 ② Yes 2 □ No 11/42If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 3/43 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Lawyer U.S. Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked James Vince Dunbar Nannie Lines 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Health end Important: If Item 27 is in any injury or other traun once. 1732 Urby Drive, Crofton, Maryland
20b. Place of Disposition (Name of cametery, crematory or other place)

Date

20c. Locati Beatrice Dunbar/ Wife 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2
☐ Cremation 3
☐ Removal from State Lakemont Memorial Gardens 1/16/2004 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** ostatic cavarnoma Immediate Cause (Final disease or condition resulting in death) /Medical 10 YV5, Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and I for use es the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? syndrome 2 No 3 Probably 4 Unknown elodusplastic Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of deeth? r this certificate has be 2 100 1 ☐ Yes 2 ☐ No 1 Tes Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Naturel 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19838 14/2004 course 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Hunapolis, Selonich, mo 31. Date filed (Month, Day, Year) JAN 1 5 2004 32. Registrer's Signature State Registrar

				State of Marylan				•	•	ie.
		_	1 - State Registrar	,		tificate of L			g. No. 20	02241
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Y	3. Time of Death
	/Medic	al	Margaret DU VERNI 4e, Fecility Name (If not institution, give s			4b. City, Town, or	Location of Deat	January	4c. County of	009 17301M
	Examin	er	Washington Cpunty				stown			ngton
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		D. Birthplece (Stete or Foreign Country)
	Director		092-30-4/62	^{M 2} ₩ 96	Yrs.	Wichians Days	Tiodis IVIII.	July 15		Maryland
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				10d. Inside City Limits
	Many -f sho find a	tor	Maryland Washingt	on	Willia	msport				1 ☐ Yes 2 No
	or 28c	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?
	ath w	by Funeral Director	16505 Virginia Ave				795		U.S.A	
	Hems frems	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No 	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	pecity Yes or No- to Rican, etc.)		American Indian, White, etc.
036	urs af		3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X☐ No	Specify:		Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. od other then "natural", or items 23a or 28e-f show event, the Medical Examinan must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	rking	6b. Kind of Busi	ness/Industry
121	within ane. then	idm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, brarian)		т .: 1.	
d 2	filed withi Hygiene. other then	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>	111	DIALLAH	18. Mother's Na	me (First, Middle, M		rary
lan	should be nd Mental marked o	To B	William R. Binkley	7			Jessie	Lehman		
Maryland	2 should and Men Is marke eumatic	ľ	19a. Informant's Name/Relationship (Typ		1			ural Route Number,	City or Town, St	ate, Zip Code)
	s 1 and 2 should f Health and Mer tiem 27 is marks other treumatic		Elizabeth Hyde - I			West Riv				Ind. 46011 ty or Town, Stete
Baltimore,	8°= 5		1 XBurial 2 ☐ Cremation 3 ☐ Re	HITOVALITOITI STATE		sition (Name of natory or other place		The state of the s		
Itin			* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			1 Cemeter Name and Addres	*	.0/04 <u>H</u> a Iinnich Fu		n, Maryland
B	permit. Departr Importe any inju		Scott 11	/ Janese	1	15 E. Wil				d. 21740
	1969 1969		23a. Part1. Enter the disease, or compile shock, or heart failure. List only on	ations that caused the deat	h. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	acute m	yocar	dial infi	arction			1 day
	/Medical Examiner		1000tting in oboting	Due to (or as a conseq	tience of):					
e*		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Oisease or injury	Due to for as a conseq	uenca of).					
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,092	De exe cian a purial-		resulting in death) Last	Due to (or as a conseq	uence of):					
687	<u> </u>	dicai	d							
Box (The law requires that the death certificate Eate has been signed by the attending physic page 2 should be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome of pregna		75			23d. Date	of delivery
	ie death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	n Day Year
P.0	that the de ad by the detached	Phys	9 ☐ Unknown Part II. Other significant conditions con		and the second		- in Donal	22a Did taha	and una contrib	ute to the cause of death?
	ires tha signed d be de	d by	Part II. Other significant conditions con	induting to death but not res	uning in the u	nderlying cause give	en in Parti.	1 \(\text{Yes}	-	☐ Probably 4 ☐Unknown
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α	The lav	dmo						autopsy perform	ed3 dea	or to completion of cause of ath? Yes 2 No
ital		BeC	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 only one		7100 2010
of Vital	Physician: rthis certification and director, it	To	1 195 2 190		R/Outpatier		er: 4 🗌 Nursing H	lome 5 Resider		
	ling P	lon:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	Work	/at <br Yes 2 ∐No	28d. Describe how	v injury occurred	
Division	or Attending Physician: after death. Director: After this certific in by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, sti		163 2 110			or Rural Route Number,
Οįς	after after I Dire	Certification:	4 Homicide	building, etc. (Specif	y)			City or Town,	State)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	ician: To the best of my known: or: On the basis of examina	owiedge, deat	h occurred at the tim	ne, date and place pinion, death occi	e, and due to the car	use(s) and mann	er as stated.
	the h the F the F	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License				Month, Day, Year)
			Cynthe K	ettre - So	and			7		y 6, 2007
•	5		· '			1				
	H'S		Dr. Cothia Kutter	Sands 14217	f farac	lise Churc	h Koad, t	ragers to	an' Ma	ryland
	Sta Regist		30. Name and address of person who co Dr. C. n.+h.c.a. Kutter 31. Date filed (Month, Day, Year)	32. Registrar's Signa	A. A	sarked				

State of Maryland / Department of Health and Mental Hygiene

				Otate of W	iaiyiaiiu	•	rtificate of	Death		Reg. No.	NL	0221.2
			1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	ith	Make .	3. Time of Death
	Physici /Media		Wii	lliam Henry	DeWit	t			Januar	y 14, 2	Year 004	8:59 a.m
	Examir		4a Facility Neme (If not institution,	give street and number)			4b. City, Town, or I	ocation of Death	4c. County	of Death	
			Garrett County					0akland			rret	t
	Funeral			6. Sex 7. As 1 ☑ M 2 ☐ F	ge (In yrs. last	birthday) Yrs.	Months Days		8. Date of Birt (Month, Day	Year)	9. Birth	place (State or Foreign ntry)
	Director		217-28-9988 Usuel Residence of Decedent	R	70	115.			Nov. 1	6, 1933	MD	
	Mend Mend		10a. State 10b. County		10c. City, T	own or Le	ocation					10d. Inside City Limits
	Man	ţo	MD Garı	rett	Oal	k1ano	1					1 ∏ Yes 2 □ No
	th the	Je C	10e. Street and Number			стапс	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	safter death with the Maryler or items 23a or 28a-f show arring must be notified at	Funeral Director	400 Glades V	Vest			21	.550		US	A	
	r dea	ne.	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of	Hispanic Origin? (Sp pan, Mexican, Puert	pecify Yes or No-	14. Rac	e - Americk, White,	can Indian,
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show mt, the Medical Examiner must be notified at	Completed by Fu	1 ☐ Never Married 2√2 Marrie 3 ☐ Widowed 4 ☐ Divorced			1	1 □ Yes 2 🖳 No				w. Whit	
5-0	72 hours "natural",	etec	15. Decedent's (Specify only highest	Education grede completed)	1	6a. Dece	dent's Usual Occu	pation during most of worl	cina	16b. Kind of B	usiness/In	dustry
12	He in the second	ğ	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of world)	9	TT	-	
2	filed v Hygie ther ti		12. Father's Name (First, Middle, La	0.04)		Ma	aintenanc		- (5:-A A5:4#	Hospit		
and	8 2 8 8	o Be		DeWitt				18. Mother's Nam Clara		maiden Suman Spoer1e	•	
Z	should and Men merke umetic	۲	19a. Informant's Name/Relationshi		1.	Ob Maili	ng Addrnas /Strac	t and Number or Ru				- Onda)
Ma	475	i	P. Edward DeWitt				orchid St		kland, l			(Code)
ē,	s 1 and if Haelth Item 27 other tr		20a. Method of Disposition		20b. Place	of Dispo	osition (Name of matory or other pla	ī		20c. Location -		own, State
Ë			14 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Cemetery	,	1/17/04	0ak1ar	nd, M	arvland
alti	permit. Pega Dapartment o important: If any injury or pncs.	- 1	21. Signature of Funeral Service Li		-		2. Name and Addre		_	Box 24		
Ω	885.8		1 Levia 1	1 93 unda	ck	Т	Durst Fun	eral Home			-	50
			23a. Parti. Enter the disease, or consheck, or heart failure. List or	omplications that cause	d the death. [-	2133	Approximate
	Physician		or riser rendre. Elector	ny one eduse on econn							1	Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	aacute m	ivocar	dia	l infar	ction			1	45 min
п		-	resulting in death)		Due to (or as						i	10 111211
Т	ted nslt	edical Examiner		■ batherc				ovascula	r dise	ase	-	yrs
-	The law requires that the death certificate be executed ate has been signed by the attending physicien and pege 2 should be datached for use es the burial-trensit	Exal	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as	a consec	quence of):				İ	
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	tifical og ph es th	Med	resulting in death) Last		•							
Вох	th cer endir ruse	2		■ d_esopha	igea1	can	cer				- i	1 yr
Ш	daai he att	200	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the u	nderlying cause giv	en in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?
P.O.	d by the	Physician/							1□ Y	es ŽŪNo	3 🗆 Prol	bably 4 Unknown
Š,	signa d be d	5										
Division of Vital Records,	v requires that tha daath ce been signad by the attendii should be datached for use	Completed							24a. Was e perfor		ava	ere autopsy findings ailable prior to moletion of cause
æ	has be 2 to 200	립									of	mpletion of cause death?
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5	sicia certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:	a Wien	0	nt 3 DOA Oth	26. Place of Deat				
o	Phy or this eral d	٦. ا	27. Manner of Deeth	1 ☐ Inpatie		o. Time of	IL 3LI DOA	4 □ Nursing Ho	me 5 Reside			0
o	ading th. : Afte e fun	뢽	1X Natural 5 ☐ Pending 2 ☐ Accident investigat		y Year)	Injury		rk? Yes 2 □ No				
N N	Atter octor by th) E	3 Suicide 6 Could not determine		ury - At home,	farm, str	eet, factory, office		28f. Location (Si	reet and Numb	er or Rura	l Route Number,
۵	s after or ed in Oir	Certification:	4 G Tromoto	Dukung, et	с. (эрвспу)				City or Town	i, Siale/		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Ex	Physician: To the best of maniner: On the basis of	of my knowled exemination	ge, death	occurred at the tir	me, date end place,	and due to the cr	ouse(s) and ma	nner as st	ated.
	the the the F	Med	one)	and manner sta	ated.							
	다. 돌 다 등		29b. Signature and title of certifier	1) it E			29c. Licens		2	9d. Date signed $0.1-1.4$ -		
•			1 Journ	4 chlor			D30			01-14		-
			30. Name and address of person wh					ial Dri	ro Oalel	and 1	MD 2	1550
	Stat	e	31. Date filed (Month, Day, Year)	Richter,	M.D. ar's Signature	153	₁ Memor	Tal DLI	ve Uaki	.ana,	. 1.1. 2	
	Registra			1 5 200	Caller	B	Anorth	(I)				

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Physician January 8 2004 Edward Eugene Everhart 4:58 am /Medical 4c. County of Death 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Washington Williamsport Nursing Home Williamsport If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec 25, 1919 5. Social Security Number Birthplace (State or Foreign Country) Mar y land 6. Sex 7. Age (In vrs. lest birthday) **Funeral** Months 1 M 2 □ F 84 Yrs. Director 214-09-0419 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes aXXNo Hagerstown Maryland Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11337 Rock Hill Road 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 2 Yes, 2 □ No 1939— If Yes, Give Year or Dates: 1965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: ğ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Cashier Horse Racing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence E. Everhart <u>Sarah Catherine Shaffer</u> 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Shirley Everhart - Wife 11337 Rock Hill Road Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1-12-04 Hagerstown, Mary Land 21. nature Funera Se in 12 e OSBOTANE AND AND STATE OF THE PLAN P.A. 425 S. Conococheague St. Williamsport, Maryland Page. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) appration Theumonic Due to (or as a consequence of) Examiner Parkinsons Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physiclan/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes an autopsy Cerebrovascular Accidents Hypertension 25. Was case referred to medical 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No

/Medical Examiner or Attending Physician: The law requires thet the death certificete be executed Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral

should be filed within 72 hours efter death with the Marylend nd Mentel Hygiene. marked other than "natural; or items 23s or 28e-f show

permit. Pages 1 end 2 should be Depertment of Heelth end Mente important: if item 27 is marked eny injury or other treumatic ev

Baltimore, Maryland 21215-0020

Canuary 8,2004

Eugen

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Degrate Kuther band, no

6 Could not be determined

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Williamsport Nursing Home, 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

D47451

January 8, 2004

Kuttner-Jands, MD. 31. Dete filed (Month, Day, Year)

W.IIIamypost

13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

154 North Artizan Street Maryland 21795

State Registrar

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

DHMH 16 Rev 6/95

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For Stata Registrar		Marylan	-	artment rtificate			and M		ag. No.	200	4 (1226
	Physici	an	Decedent's Name (First, Middle, La	•	1-	G					Date of Dear Month	Day	Year		e of Death
	/Medic	al	Clarence			Sr.	41 21				Januar				50 a M
j	Examin	er	4a. Facility Name (If not institution, giv		oer)		4b. City,		Location o	_		4c. C	ounty of Dear Cari		
			1304 Hillcrest S 5. Social Security Number 6.5		. Age (In yrs.	last hirthday)	If Under		pstea If Under		8. Date of Birth				ata or Foreign
П	Funeral Director			M 2□F	. Ago (<i> yı</i> s. 7		Months	Days	Hours	Min.	(Month, Day,	Year)			ate or Foreign
			Usual Residence of Decedent								Jan 8,	T337	Ma	rylan	<u>a</u>
	ylanc Now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insid	le City Limits
	a-f s	tor	Maryland Carr	oll					Hamps	stead	i			10	Yes 2 ₁ √2No
	or 28	Jre	10e. Street and Number				10f. Zip	Code			1	0g. Citize	n of What Co	ountry?	
	23a	Funeral Directo	1304 Hillcrest	Street					21074				USA		
	r dez	nue	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Deced If Yes, spec	ent of Hi rfy Cuba	ispanic Origin, Mexican	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)	14	. Race - Ame Black, Whit		٦,
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	□ No 195		1□Yes 2	∑ No	Specify:			s	pecify:	white	2
8	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itema 23a or 28a-f show out, the Madical Examinar must be rollified at	ed b	15. Decedent's E	Year or Date	es: 195		dent's Usua	l Occup	ation			16h Kind	of Business/		
5	in 72 an" r	ojet	(Specify only highest gra	de completed)		(Give	kind of wor DO NOT us	k done d e retired	during most	t of worki	ng	TOD. KING	01 20311033	industry	
7	y with jiene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		Meat						Meats		
ਰੂ	othe othe	Be C	17. Father's Name (First, Middle, Last,						18. Mothe	r's Name	(First, Middle, I	Maiden Si	итате)		
<u>a</u>	uld be Aental rked o tic eve	To E	Charles Washin	ngton Fro	ock				E	ster	Eva Cri	umbac	cker		
Maryland 21215-0036	es 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I fitem 27 is marked other than "natural", or Itema 23s or 28s-1 show rether traumatic event, the Medical Examinat must be rollified at		19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •			•				l Route Number				
	and and m 27 m 27 nar tr		Anna B. Frock, v	wife	<u>-</u>	-	100		est S		ampstead				
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from St		Place of Dispo cometery, crei	sition (Nam natory or ot	ie of her plac				20c. Loca	tion - City or	Town, State	э
Ē	. Paç tment tant: jury		`4 ☐ Donation 5 ☐ Other (Specif	y)	Bei	njamin					2/2004		stmins	ter, 1	MD
ga H	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licer	1See	M05723		Name and				Cline Fu			074	
_	ubi s d		230 Port Feter the disease or sem	plication that any	ceed the deat	_					Hampst		MD ZI	U / 4 Approxi	mata
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	on cause on eac	h line.	ii. Do not ent		o ayını	y, such as	Cardiac 0	respiratory arri	351 ,		Interval	Between and Death
r i	Physician /Medical		disease or condition resulting in death)	a. POO	SE	ATIC	<u> </u>	- (11					12	- illo
	Examiner			Due to (or	r as a conseq	uence of):									
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq	uence of):								_	
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oʻ	a exec an an irial-tr	Exa	resulting in death) Last		as a conseq	uence of):									
8760	death certificate be executed e attending physician and of for use as the burial-transit	dicai		d											
9	Jeath certific attending pl	Med	IF FEMALE:												
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Feta	I death 3	Ectopic pre					230	d. Date of deli Month	ivery Day	Year
o O		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9□ Unknow	nt at time of d n	eath 5∟	Other (spe	ecify)						,	
۵.	that the ed by	Ph	Part II. Other significant conditions of	contributing to dea	th but not res	ulting in the u	nderlying ca	iuse give	en in Part I.		23e. Did tob	acco use	contribute to	the cause	of death?
ds,	The law requires that the site has been signed by the bage 2 should be detache	d by									1 □ Ye	s 201	No 3□Pr	obably 4	□Unknown
Š	w require been si should I	lete									24a. Was a	n 1:	24b. Were au	tonsy findin	nos available
Record	The lav	Completed									autops perforn	y ned?	prior to death?	completion	of cause of
_		Be Co	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes 2		1 🗆 Yəs	2 No	
<u>=</u>	ysicia is cer direct	To B	examiner? 1 ☐ Yes 2 🗃 No	Hospital: 1 Inp	patient 2	ER/Outpatien	t 3 DO	A Othe			ne 5 Reside		Other (Spec	cifv)	
Division of	ding Ph h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of	28	3c. Injury Work			28d. Describe ho				
<u>Ö</u>	tendir leath. tor: Af the fu	atle	2 Accident investigation	n			М		Yes 2 □ I	No					
ž	A C S S	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	f Injury - At ho , etc. (Specif	ome, farm, str y)	eet, factory,	office		2	28f. Location (St. City or Town	reet and f , State)	Number or Ru	ıral Route ∧	lumber,
	urs af ural D ural D			<u> </u>						- 11					- 1
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exar	nysician: To the bas miner: On the bas and manne	is of examina	tion and/or in	occurred a vestigation,	in my op	ne, date and pinion, deat	d place, a th occurre	and due to the ca and at the time, da	iuse(s) an ate and pl	id manner as ace, and due	stated. to the caus	ie(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		A		29c.	License	number	-	25	9d. Date s	signed (Monti	h, Day, Yea	r)
}	101) during	Ym	V 27	MU	D	3	5 3	7 PE	>	-	DR.	-04	
	WIVA		30. Name and address of person who	completed cause	of death (Item	n 23a) (Type,	Print)		Α.			-			
	101		Flavoruter m	D'555	Sout	. 0	ter5	stree	etl	UN	minst	s r	o dor	2115)
	Sta		31. Date filed (Month, Day, Year)	_	istrar's Signa	ture		-			,,				
	Registr	ar	JAN 0	9 2004	Chalues	. 1%	Some	11							

		•	For State Registrar	State of I	Maryland		artmen <i>tificat</i>			ind Me		giene Reg. No.	2004	02	245
			1. Decedent's Name (First, Middle, Las	rt)							2. Date of Dea Month	Day	Year	3. Time of	
	Physici: /Medic		Thelma Virginia	Frock							Jan	01	2004	7:45	Ъм
è	Examin		4a. Facility Name (If not institution, give		er)				Location o			4c. C	county of Death		
			Long View Nursing		A // /	and hintholous		anch	ester		8. Date of Birt	h		DLL place (State o	r Foreign
	Funeral		5. Social Security Number 6. S	ex □ M 2/50/F /	Age (In yrs. I. 81		Months		Hours	Min.	Jan I	, Year) 6 19:	22	Intry) MD	
	Director		215-14-1888 Usual Residence of Decedent		- 61							.0			
	Maryland -f show lied at	tor	10a. State 10b. County 10c. City, Town or Location Maryland Carroll Manchester									10d. Inside City Limits 1⊠Yes 2⊡No			
	28a	Director	10e. Street and Number 10f. Zip Code 10g.							10g. Citize	en of What Co	untry?			
36	h with	<u>a</u>	3332 Main St. 21102						Ţ	USA					
	72 hours after death with the Maryland natural: or Items 23s or 28s-f show Jical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ⊠No	ł	Was Dece If Yes, spe 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: Wh		
21215-0036	d within 72 hours piene. r than "natural", r than "natural",	Completed t	15. Decedent's Et	ducation de completed)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done d	durina most	of working	g	16b. Kind	d of Business/l	ndustry	
7	within piene. r than "	E	Elementary/Secondary (0-12)	College (1-4	or 5+)	Sewi	ng Ma	chin	e Ope	rato	c	Born	nstien	& Sons	
פַ	it by g	Bec	17. Father's Name (First, Middle, Last,								(First, Middle.		Sumame)		
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Maryland	12 sh h and 7 1s n traun	9	19a. Informant's Name/Relationship (James Frock/Son										Town, State, Z D 211 58		
ē,	1 and Health Part 2 and 2 ther		20a. Method of Disposition			lace of Dispo emetery, cre	sition (Na	me of other place	e)	D	ate	20c. Loc	ation - City or	Town, State	
ē	0 0		1 Durial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specif]Removal from St y)		ce Ref				1/03	/2004	Tane	ytown,	Maryla	nd
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	1500		2:	Pritt	nd Addres S Fu	neral neral	Hom	e and C	hape mins	l, P.A. ter, M	2115	7
			23a. Part1. Enter the disease, or com	plications that cau	sed the death	h. Do not en	ter the mo	de of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approximat Interval Bet	te
	Pnysician	es 111	Shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final												
1	/Medical		disease or condition resulting in death)	Due to (or	as a consequ	uence of):		71							
ı	Examiner		Company of the line and distance	b											
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. List Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
	cate be executed oblysician and the burial-transit	Examin													
ő	e exe sian a urial-	Ä	resulting in death) cast	Due to (or	as a consequ	uence or):									
8760	ate b hysic the b	dicai		_ d								-			
Box 6	ath certific	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown		h 2∏ Feta nt at time of d	death 3	⊒Ectopic p ⊒ Other (s					2:	3d. Date of deli Month	-	Year
P.0	that the de ned by the a detached f		Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	ınderlying	cause giv	en in Part I.		23e. Did to	obacco us	e contribute to	the cause of	death?
Records,	iw requires that s been signed t should be det	d by	A (2 hour	dia	سيدده						10	Yes 2□	No 3□Pr	obably 4	unknown
Š	v requ been shoul	Completed	7 3								24a. Was	an	24b. Were au	topsy findings	available
Rec	sician: The law s certificate has t lirector, page 2 s	E E			·						autor perfo	osy ormed?	prior to death?	completion of a	ause of
		ပို	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·					26 Place	of Death	(Check only o	2 No	1 L Yes	2 □ No	
of Vital	Physician: The ribis certificate harral director, page	0	examiner?	Hospital:	nationt 2	EB/Outnatie	nt 3 🗆 D	OA Oth	00				□Other (Spec	cify)	
on of	ald ald	tion; To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury			int 3 DOA 43 Nursing Hor			me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
Division	or Attending after death. Director: Afte in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not investigation 4 Homicide determined	be 280 Place of Injury - At home form street factory office 28f Location (Str							Street and Number or Rural Route Number, vn, State)				
ш	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Ce	(Check only 2 Medical Exa	hysician: To the bas	is of examina	owledge, dea ation and/or in	th occurred	d at the tir n, in my o	ne, date an pinion, dea	id place, a	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s	s)
	To the within 2	Med	29b. Signature and title of certifier	and manne	stateu.		29	c. Licens	e number			29d. Date	signed (Monti	h, Day, Year)	
	M. Wil	_	b //				1	5076					ary 2,		
	"Es	4	30. Name and address of person who	completed cause	oldeath (leas	n 23a) (Tuna							Sales Mis		
	3				Poole			insta	r. Mr	211	58				
		ate	Frnesto Mendoza 31. Date filed (Month, Day, Year)	32. Re	nistrar's Signa	ature			- F 1'11	- 4-1-t					
	Regist		IAN O	6 2004	George	· K	Sor	110							

			For State Registrar	State of I	Marylan	-	artment of H		ind Me	-	iene g. No. 20	04	02246
	Physici	an	1. Decedent's Name (First, Middle, L John	George George	e	Fa	hy			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, g Frederick Memo	ive street and number	9r)		4b. City, Town, or	Location of erick	* -	anuary	4c. County		<u> 7:40A </u>
2	Funeral Director		5. Social Security Number 125-12-0082 Usual Residence of Decedent	Sex 7. 1 M 2 □ F	Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jan 17,	1912	9. Birthp Cour New	otace (State or Foreign http:// York
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 2121	Maryland s-f show iffed st	tor	10a. State 10b. County Maryland Freder:	ick	10c. Cit	y, Town or Lo Frede				-		1	0d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28	I Dire	10e. Street and Number 7401 Willow Road	1			10f. Zip Code	702		1	0g. Citizen of V	What Cour	ntry?
920	72 hours after death with the Maryland Insturel, or items 23a or 28e-1 ehow ofcal Exeminer must be notified at	by Funeral Director	11. Maritat Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 ½ Yes 2 If Yes, Give Year or Date	s? □ 1 943-	_ 1	Vas Decedent of Hi f Yes, specify Cubar □ Yes 2 No	spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)	Blac	e - Americ ck, White, v: Whi	etc.
21215-0	d within 72 ho giene. or then "natur i the Mcolcal.	Completed by	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		or 5+)	16a. Deced (Give life. I Senic	lent's Usual Occupa kind of work done d DO NOT use retired, T Vice-Pr	ation luring most ceside	of working ent	g	16b. Kind of Bi Bankin		dustry
yland	ould be file Mental Hy arkad oth atic event	To Be (17. Father's Name (First, Middle, Las Patrick	Fal	hy			Bridg	get	(First, Middle, I	Spa	ight	
, Mar	and 2 sh salth and n 27 ls m er traum		19a. Informant's Name/Relationship Loretta B. Fahy/			19b. Mailir 8903	g Address (Street a Remingtor	nd Number n Plac	ce, F	rederic	ck, Mar	state, Zip yland	Code) 21701
imore	Pages 1: ment of He ant: If Item ury or oth		20a. Method of Disposition 1X Burial 2 Cremation 3 4 Donation 5 Other (Spec		. 0	emetery, cren een of		netery		21, 20		t Pal	m Bch, FL
Balt	Departi Departi Import any inj		21. Signature of Funeral Service Lio	ew	M007	706 10	Name and Addres Keeney 6 East Ch	s of Facility & Bas nurch	sford St,	P.A. F Frederi	uneral ck, Ma	Home rylan	d 21701
	Physician /Medical Examiner		23a. Pant. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	as a conseq	h. Do not ento	er the mode of dying	, such as c	ardiac or	respiratory arre	izeas		Approximate Interval Between Onset and Death
3760,	sate be executed shysicien and the burial-transit	Ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	c	as a consequal as a consequal								
O. Box 6	that the death certifice ed by the attending pr detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				23d. Dat Mor	e of delive	ry Day Year
0_	w requires that been signed b should be deta	by	P and in other significant continuous continuous to death but not resulting in the underlying cause given in Parti.								23e. Did tobacco use contribute to the cause 1 ☐ Yes 2 2 2 No 3 ☐ Probably 4		
al Reco	iicien: The law requ certificate has been rector, page 2 shouk	Completed	Prostate	Canci					24a. Was an autopsy performed? 1 Yes 10 10 1 Yes 2 No			npletion of cause of	
ا چز	ysicien is certifi director	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} 2 \text{Yes} \)	Hospital:	itient 2 🗆	ER/Outpatien	3 DOA Othe			Check only one 5 □ Reside		er (Specity	')
Vision of Vital Records, P.O. Box 68760,	ttending Physideath. death. stor: After this rithe funeral di	atlon:	27. Manner of Death Natural 5 Pending 2 Accident investigati	a. Date of Ir (Month, L		28b. Time of Injury				dome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
Divis	Dir	Certification:	3 Suicide 6 Could not determine	d 250. Place of	Injury - At ho etc. (Specif)	ome, farm, stre	et, factory, office		28	f. Location (Str City or Town	eet and Numbe , State)	er or Rural	Route Number,
	n 24 hours n 24 hours he Funerel bletely filled	edical	29a. Certifier Check only 2 Medical Executed (Check only one)	Physician: To the beaminer: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred at the time estigation, in my opi	e, date and inion, death	place, an occurred	d due to the ca at the time, da	use(s) and ma ite and place, a	nner as sta and due to	ated. the cause(s)
•		¥	29b. Signature and title of certifier	E. Ch.	112	MD	29c. License	number 428		29	d. Date signed	(Month, E	Day, Year)
	8		30. Name and address of person who Casper E. Cline,					eet.	Fred	erick.	Marylan	nd 21	1 701
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signa	ture	1 0	aks					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 1110 AM January 14, 2004 /Medical 4a Fecility Neme (If not institution, give street end number) City, Town, or Location of Deeth 4c. County of Death Examiner arro 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) 6. Sex **Funeral** Months Days 1 M 2 F Yrs. 214-10-1361 March 24, 1919 Maryland Director Usual Residence of Decedent be filed within 72 hours efter death with the Marylend 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo or 28a-f t Maryland Carrol1 Sykesville 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 710 Obrecht Road 21784 U.S.A. or items 23a Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2ఏ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: if tem 27 is merked other than "ne any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Scott Luther Study Roma Arlene Markoe 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roscoe Ted, Fowler (Husband) 7200 3rd Avenue #211, Sykesville, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 1/17/04 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 ath. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Physician **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to for as a consequence of) Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours eliter death.

To the Fureral Director: After this certificate has been signed by the ettending physician and completely filled in by the Inneati director, page 2 should be deteched for use as the burlar-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tes 20110 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature end title of certifier 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

State

Registrar

JAN 1 6 2004

DHMH 17 Rev 1/2001

mary

Division of Vital Records. P.O. Box 68760.

		For State Registrar	State of	Marylan		artmen					giene Reg. No	200	11.	023	21.0
		Decedent's Name (First, Midd	lle, Last)							2. Date of De	ath		, cub	3. Time of [Death
Physicia /Medic		Alex Arthur F	ulton			,				Month Januar	р 2,	2004	ar	0702	М
Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death		4c.	County of [
		Chester River			last hirthdayl	If Under		ertov If Under		9. Date of Bir	•b	Ke		- Ctata -	Coming
Funeral Director		5. Social Security Number 353–28–2866	1 M 2 □ F	7. Age (In yrs.) 68	Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, Da Aug. 1	y, Year) 5 1	.935	Count	ace (State or ry) Lnois	roreign
	}	Usual Residence of Decedent	71							ado. I					
anylan show	_	10a. State 10b. County	4		y, Town or Lo								10	id. Inside City 1,☐ Yes	•
he Ma	Director	Md. Que	een Anne		Millin	gton 10f. Zip	Codo				10a Cit	izen of Wha	t Count	_X	
with a or	급		T ama				1651				iog. Cit		SA	y :	
death	Funeral	102 Springviev	12. Was Dece	dent Ever in U.	.S. 13. \	Was Deced	ent of His	spanic Ori	igin? (Spec	cify Yes or No)-	14. Rece - /	America		
after or Ite		1 ☐ Never Married 🍇 Ma	rried Armed For 1 Tes If Yes, Giv	2 No		if Yes, spec 1 ☐ Yes :	_	Specify:		tican, etc.)	}	Black, V Specify:	Vhite, e	IC.	
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n 72	Completed	(Specify only high	nt's Education est grade completed)		16a. Deced (Give	dent's Usua kind of woi DO NOT us	k done di	uring mos	t of workin	g	16b. K	ind of Busin	ess/Indi	istry	
Jwith Jiene Ther	mo	Elementary/Secondary (0-12)	College (1	-4or 5+)	Hea1	th Ca	re C	onsu	1tant		Se	1f Em	ploy	zed .	
e filec al Hyg I othe vent,	Be C	17. Father's Name (First, Middle	, Last)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)			
ould b Ments arkad atic e	Tol	Alex John Ful			_					uth Ro					
12 sh h and 7 is m traum		19a. Informant's Name/Relation Peggy Osborn				•				Route Number					
1 and Healt Ham 2		20a. Method of Disposition	ruiton	20b. P	lace of Dispo	sition (Nan	1e of	1		ate		ocation - City			
Pages ent of nt: If if		1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (state	emetery, cren sapeak				1/7/2	004	Stev	ensvi	11e.	Mary	land
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Informatic it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Mardical Exist it at most be notified a once.		21. Signature of Funeral Service			22	2. Name an	d Address	s of Facilit	ty					-	
1 ឱ៥៩៩៩		Ham/B	. Feller	W3		O Spe	, не er R	oad (peın Chest	& Newn ertown	ат г , Ма	unera rylan	$\frac{1}{1}$	me, P .620	.A.
		23a. Part1. Enter the disease, of shock, or hear failure. Lis	or complications that ca it only one cause on ea	aused the deeth ach line.	h. Do not ent	er the mod	e of dying	, such as	cardiac or	respiratory a	rrest,			Approximate Interval Betw Onset and De	veen
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		PSIS										20 hrs	
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icate licate physics the t	edical		d										+		
leath certific attending p	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		DEctopic pr	2002001					23d. Date of	deliver	y	
ne deatl	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of de		Other (sp						Month	C	Day Ye	ear
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uires that signed t	d by	Van Wall	ebvands	, Hepa	AttsC	-	2000 g.10	· · · · · · · · · · · · · · · · · · ·		101		· ·] Proba		nknown
w require been si should l	Completed	Denoher	100, ward	islace.						24a. Was		24b. Were	autop:	sy findings av	vailable
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ian: ortifica ctor, p	Be C	25. Was case referred to medic examiner?		-para-			····	26. Place	of Death	(Check only o	/				
hysic this ce	ပ္	1 ☐ Yes 2 X No			ER/Outpatien			4 LI NU		e 5 Resid			Specify)		
Jing F	lon:	27. Manner of Death 1 Natural 5 □ Pend	ing 28a. Date of (Mont)	h, Day Year)	28b. Time of Injury	M	8c. Injury Work	at ? ′es 2.∐l		8d. Describe I	now injur	y occurred			
Attending Physician: The Attending Physician: The Attending Physician: The Goath. ector: Attenthis certificate h by the funeral director, page	ertification;	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At ho						8f. Location (S			r Rural	Route Numb) <i>er</i> ,
s after	Certi	4 Homicide determined	buildir	ng, etc. (Specify	y) 					City or Tov	vn, State)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attended to the theorem of the continuate the continuation of the continua	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the I Examiner: On the ba and mann	isis of examina	wledge, death tion and/or in	h occurred vestigation,	at the time in my op	e, date an inion, dea	nd place, ar oth occurre	nd due to the d at the time,	cause(s) date and	and manne I place, and	r as sta due to t	ted. he cause(s)	
To the within To the comp	M	29b. Signature and title of certifi	er	1			. License				29d. Dat	te signed (M		ay, Year)	
		16	\bigcirc V	ريس			000	548	890		- 1	12/01	1		
		30. Name and address of person	1 1/ D	((00	01 1	TT - 7 7	D.e.	J (1)	a a t = :	ha 1	Me		21.00	10	
Sta	ite	Dr. Heather M 31. Date filed (Month, Day, Yea JAN	orpny, M.D	egis ar's Signa	ture	<u> </u>	коа	a Che	ester	rown,	Mary	and	4. L b2	.UU.	
Registr	ar	JAN	0 / 2004	Marie Land	J.J.	6034									

			1 - For State Registrar	State of Maryla	nd / Dep	artment of He rtificate of D	ealth and I	Mental Hygie	ne2004	02250
			Decedent's Name (First, Middle, Las	:1)				2. Date of Death		3. Time of Death
	Physici		Rodger Alvin Farle	.v				Month January	12, 2004	7:25 P ^M
	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	
			Anne Arundel Medic	:al Center		Annapolis	S	A	Anne Arun	del
	Funeral Director		491-10-6723	7. Age (In yrs	s. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Feb. 27,	9. Bi 1918 Mis	nthplace (State or Foreign ountry) SOUTI
	filed within 72 hours after death with the Maryland Hygiene ither than "naturat", or fleme 23s or 28s-f show ont, the Medical Examinar must be notified at	lor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arun		City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a	Funeral Director	10e. Street and Number	idei fillia	тротта	10f. Zip Code		10g	. Citizen of What C	ountry?
	h with	D E	105 Bay Drive			21403		Uni	ted Stat	es
	deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cubar	panic Origin? (S	pecify Yes or No-	14. Race - Am	
9	or Ite	正	1 Never Married 2 Marned	1 XYes 2 No 19	142-	1 ☐ Yes 2X No		o rican, etc.)	Black, Whi	
	ral',	d by	3 Widowed 4 □ Divorced	Year or Dates: 19	945	103 200 110	Specify.		Specify: W	mr ce
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or lieme 23a or 28a-1 show event, the Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of wor	king 16	b. Kind of Business	/Industry
	ygien gerth t, the	Con		5+	Profe	ssor		Te	eaching	
2	be file ital Hy id oth event	Be (17. Father's Name (First, Middle, Last)			1		ne (First, Middle, Mai	iden Sumame)	
<u>X</u>	2 should be n and Mental le marked o raumatic eve	^o L	John Wesley Farley				Norma Sc			
Maryland	is 1 and 2 should of Health and Mer Item 27 te marke other traumatic	- 1	19a. Informant's Name/Relationship (7 Norman Farley / So	• •		ng Address <i>(Street ar</i> illiam Mea				<i>Zip Code)</i> Ma r yland 210
	1 and Health em 27 ither tr		20a. Method of Disposition						. Location - City or	
Baitimore,	Pages nent of I int: If Its iry or o		1 ☐ Burial 2 💢 Cremation 3 🗍	nemovar nom State		osition (Name of matory or other place e Cremator	1/1/	/2004 Bal	•	
≣	permit. Page Department Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other Specify 21. Signature of Funeral Solid License		_		_			
ä	permit. Pages 1 Department of H Important: If Itel any injury or otl once.		Mahalla			147 Duke o	of Glouce	nn M.Taylo ester St	r Funera Annapoli	1 Home, Inc. s, MD 21401
	j.		23a. Part1. Enter the disease, or composhock, or heart failure. List only of	dications that caused the dea	ath. Do not en	ter the mode of dying	, such as cardiac	or respiratory arrest,	mmaport	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a conse		5 0156	013			won 18
	Examiner		Sequentially list conditions	b						
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	certifica Iding ph	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregr	nancv				23d Data of da	li
X P P	death death of for u	clar	in the past 12 months?	1 Live birth 2 Fet	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
j.	the d	lys	1 Yes 2 No 9 Unknown	9□ Unknown						
ت. ح	requires that leen signed b hould be deta	by Pi	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	nderlying cause giver	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ğ	w requires that been signed to should be det	leted b						1 ☐ Yes	2,2 No 3 □ P	robably 4 🗆 Unknown
Hecord	~ Q /A	plet						24a. Was an	24b. Were at	utopsy findings available completion of cause of
	0 5 0	ompl						autopsy performed 1 ☐ Yes 2 Ø	☑ death?	completion of cause of
VITAI	ician: Th certificate rector, paq	Se C	25. Was case referred to medical				26. Place of Dea	th (Check only one)	10 10 18	2010
-	ys S S D	To B	examiner? 1 Tes 2 No	Hospital: 1 Impatient 2	☐ ER/Outpatier	Other		ome 5 Residence	6 ☐Other (Spe	cify)
n 01	ding Phys	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of !njury (Month, Day Year)	28b. Time of	f 28c. Injury a Work?	at	28d. Describe how i		
<u>0</u>	Attending r death. sctor: Atter by the fune	catle	2 Accident investigation			M 1□Y	es 2□No			
JIVISION	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	reet, factory, office		28f. Location (Stree City or Town, S.	t and Number or Ri tate)	ural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Ce	29a. Certifier 1 Certifying Phy	ysician: To the best of my kn	nowledge deat	h occurred at the time	date and place	and due to the	a/s) and man	etated
	To the Hospital within 24 hours a Cothe Funeral I completely filled	edical	(Chack only 2 Medical Exam	iner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my opi	nion, death occur	red at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	within To th	Me	29b. Signature and tille of certifier	1		29c. License	number	29d.	Date signed (Mont	h, Day, Year)
			> /ABV/	- W		DOD	51301	Ta	nus 13.	2004
			30. ame and apdress of person who c	ompleted cause of death (Ite	m 23a) (Type,	Print)		200	,	uc uneco
			their & throng	MO 900	P5+4	THE ROW	1 suffe	300 A	h olis	402140
	Sta		31. Date filed (Month, Day, Year) JAN 15 2	32. Registrar's Sign	ature	1		1		,
	Registr	वा	AULI TO C	THE STATE OF THE S	Nº A			l		

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 9, Helen Sullivan Fitez January 2004 4:00 A /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mallard Bay Care Center Cambridge
If Under 1 Year | If Under 24 Hrs. Dorchester 8. Date of Birth (Month, Day, Year) July 10, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XF Yrs. 220-01-5400 84 1919 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show eny injury or other treumatic event, the Medical Exercitions. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗷 No Completed by Funeral Director Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5708 French Farm Road Baltimore, Maryland 21215-0036 🕠 🏌 21631 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) account representative telephone company 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Sullivan Gertrude Dehaven ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Daniel Fitez 5708 French Farm Road, East New Market, MD 21631 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 1/16/04 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 **Physician** a no SPUCIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit iding physicien and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached to 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 X Ng 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Dolo Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Norsing Home 5 ☐ Residence 6 ☐ Other (Specify) nous after death.

neral Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) a 16 30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print) Lois A. Narr D,O. (Antie 31. Date filed (Month, Day, Year) JAN 13 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

JAN 29

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Zoo 4 Month **Physician** 07:40 AM GLUNOZS GILBERT MAMSA7 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner unryer w MARTIMA & sommers MERLAND BALTIMORE MEDICAL CRATER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 03 23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F 215-16-8868 85 Yrs. 1918 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 6270 QUAKER NECK LANDING RD 21620 USA items 23a Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No !! Yes, Give 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item eny injury or other traumatic event, Item Medical Executary. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2💢 No Specify: Specify: BLACK 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE FAMILY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SYLVESTER LINDSEY ANNA SAUNDERS ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Colony Dr. Apt. Chestertown, RONALD GILBERT, SR. - SON MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 14 Burial 2 Cremation 3 Removal from State EMMANUEL U.M. 1/17/04 POMONA, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Kenneth Wa Service 821 Annapolis,

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Kenneth Walley Funeral Service 821 Annapolis, MD 21401 Approximate Interval Between Onset and Death Avance Pnysician Ununum 18 drs resulting in death) /Medical Due to (or as a consequence of): Examiner cower Corcagne Express 47 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit DECUINC and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Vounte DISEASE Honora 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? RENUM f Selen RE 24a. Wasan ALLINT has autopsy performed? (es 2 No Primoning Frencherel certificate Hospital or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral C TC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6, 7004 Tannan? Sneown (295 108NT) Mb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cours Bowning MMOZUM MULANIBLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For Amend Item#20b	State of Ma perFHC827 1/3	ryland / Dep. 30/04 Ew Ce	artment of Health and rtificate of Death	Mental Hygi	iene 2004	02254
			1. Decedent's Name (First, Middle, Las	it)			2. Date of Death	h Day Yeer	3. Time of Death
	Physicia		Dr. Nelson F	rescott	Guild		/ -	05 - 04	16:20 M
	/Medic Examin	_	4e. Fecility Neme (If not institution, give	street and number)		4b. City, Town, or Location of Dea		4c. County of Death	
			SACRED HEAD	RT HOS	PITAL	CUMBERLA		ALLEG	
ı	Funeral Director		002 10 3317	ex 7. Age ☐M 2☐F	75 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day,	Year) 9. Birth Co. 1928 Kee	place (State or Foreign intry) ne, NH
	pu &	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	sho	5	MD Allega	ınv	Frostbu	ra			1 ☐ Yes 2√∑ No
	with the h te or 28a-1 I be notiffi	Direct	10e. Street and Number 28 Teaberry La			104. Zip Code 21532	11	0g. Citizen of What Cou USA	intry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinermust be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Types 2 Types, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puei 1 Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Rece - Amer Black, White Specify: W	
21215-0036	ithin 72 hou se. sen "neture s Medical E	npleted	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	de completed) College (1-4or 5	(Give	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) resident FSU	prking	Educati	,
and 21	d be filed wintal Hygien and other th	Be	12 17. Father's Name (First, Middle, Last, Louis F. Guild			18. Mother's Na	me (First, Middle, M Mason Gu	Maiden Sumame)	0.11
Maryland	d 2 should the and Me 27 is mark traumatic	2	19a. Informant's Name/Relationship (Margaret Guilo	Type, Print) I – Wife	19b. Mail 28	ing Address (Street and Number or F Teaberry Lane,	Pural Route Number Frostbu	. City or Town, State, Z urg, MD 2	ip Code) 1532
Baltimore,	Pages 1 and 2 ant of Health ant: If If Item 27 i	ĺ	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State		osition (Name of Innatory or other place) NH Cemetery	/2004	20c. Location - City or T Keene	Fown, State
Baltir	permit. Pages Department of the Important: If Ite any Injury or of		21. Signature of Funeral Service Lice			2. Name and Address of Facility	1302 Nat	tional Hw land 2150	-
*	Fnysician /Medical		23a. Pert1. Enter the disease, or comshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. 751	a consequence of):	nter the mode of dying, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	be executed cian and purial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):	rustive Can	Disp	656	
P.O. Box 68	The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the i	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	,	* 23d. Date of deli Month	very Day Year
	quires that n signed b	by	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause given in Part I.	23e. Did tot	bacco use contribute to es 2 □ No 3 □ Pro	the cause of death?
Division of Vital Records,		Completed					24a. Was a autops perform	med? prior to death?	topsy findings available completion of cause of 2 ☐ No
ita	sian: artific ctor,	Be (25. Was case referred to medical examiner?			CONTRACTOR OF THE PARTY OF THE	eath Check onl on	18	
, _ _	hysic this ce al dire	ို	1 ☐ Yes 2 🚉 No	Hospital:		10 march 20 m	41	ence 6 Other (Spec	eify)
ם י	ding Ph I. After th funeral	on:	27. Manner of Death 1 → Hatural 5 → Pending	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injury	Work?	28d. Describe ho	ow injury occurred	
, v ivisio	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director, i	Certification;	2 Accident investigation 3 Suicide 6 Could not to determined	28e. Place of In	jury - At home, farm, s tc. <i>(Specify)</i>	M 1 ☐ Yes 2 ☐ No street, lactory, office	28f. Location (Si City or Town	treet and Number or Run, State)	ral Route Number,
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier 1 S-Certifying P (Check only one)	hysician: To the best miner: On the basis of and manner st	of examination and/or i	ath occurred at the time, date and plainvestigation, in my opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
1	To the within 2 To the complex	Mec	29b. Signature and little of certifier	/1/4	1/1	29c. License number		9d. Date signed (Month	
	20		30. Name and address of person who	completed cause of	teath (Item 23a) (Type	a. Print) 1/25 Ston D.	rive (u	nberlan	1 ms
	Sta Regist		31. Date liled (Month, Day, Year)	32. Aegist N 2 9 2004	rar's Signature	di Sartis			

State of Maryland / Department of Health and Mental Hygiene 2001

						Cer	tifica	te of	Death			Reg. No.	-004	02233
	D		1. Decedent's Neme (First, Middle, Last)								2. Date of De	eth Day	Year	3. Time of Death
	Physicia /Medic		Melba Venith GARMO	ONG							Jan.	11, 20		12:30 p.m.
	Examin	_	4a Fecility Name (If not institution, give s	street end number)					-		cation of Deet		ounty of Deeth	
			Coffman Nursing H						_	gerst			Vashing	
	Funeral Director		218-30-9599	7. Age	100	birthdey) Yrs.	Months	Days		Min.	8. Date of Bir (Month, De May 6,	y, Yeer)		place (State or Foreign htry) yland
	pu }	-	Usuel Residence of Decedent 10e. State 10b. County		10c. City, To	own or Loc	cation						1	10d. Inside City Limits
	Anyle	5	Maryland Washing	rton		ersto								1⊠Yes 2□No
	28a	Director	10e. Street end Number	con	mag.	CISCO	_	p Code				10g. Citizer	n of What Cour	ntrv?
	ter death with the Maryler tems 23s or 28s-f show the mast be motified at	la Di	1533 Sherman Aver						21740			USA		
020	within 72 hours efter death with the Marylend ene. Han "netural", or terms 23a or 28a-f show the Medical Examiner meat be notified at	by Funeral	11. Merital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		If	Vas Dece Yes, spe	ecify Cub	an, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Black, White,	
ဂ ဂ	72 ho	Completed	15. Decedent's Educ (Specify only highest grede	cation completed)	16	Sa. Deced	kind of w	ork done	during mos	t of worki	ina	16b. Kind	of Business/In	dustry
2	ighi.	ğ	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. D	O NOT	ise retire	id)					1
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စ်	Heal Heal John 2	ł	20a. Method of Disposition	11000	20b. Place	of Dispos	sition (Na	me of			Date		tion - City or To	
Imore,	nit. Peges ertment of l ortant: If It Injury or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	rtery, crem Paul					1/15/04	Cle	ar Spri	ing, Md.
Dal	permit. Depenti Importi any inj		21. Signature of Funeral Service License		c «	/					NNICH F			21740
		_	23a. Part1. Enter the disease, or compleshock, or heart failure. List only	11/1/1	nule						_		11, 11G.	Approximate
	Antificete be executed fing physician and fing physician and fine physician and see as the burial-transit	Medicai Examiner	immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	. fle	Due to (or as	e consequ	uence of	M2	cula		Asle	ul	7	15 Jeans 715 Jeans
_	th ce tendii r use												!	
	e death he etter ned for u	Physician	Part II. Other significant conditions con	tributing to death bu	t not resulting	g in the un	derlying	cause gi	ven in Part I		23b. Dld	tobacco us	e contribute to	6 the cause of death?
7.	thet the	F.	noul								10	Yes 2 D	No 3□ Pro	babty 4 ☐ Unknown
	requir	Completed by		•							24a. Was	en autopsy rmed?	av	ere autopsy findings ailable prior to pletion of cause death?
	The 1 ate he page	Ĕ١									15	Vas 21/21	0 1[∃Yes 2□No
	sician: The law certificete hes t lirector, page 2 s	Be	25. Was case referred to medical examiner?					4=		of Deat	Check only	one)		
>	Physician: this certific ral director,	2	1 Yes 2 No	ospital: 1 🗆 Inpatier	nt 2 ER/	Outpatient		UA		irsing Ho	me 5□ Resi	dence 6 🏻	Other (Specif	(y)
	ding Pt th. After th funera		27. Menner → Peth 1 → atural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Dey	Year) 28t	o. Time of Injury	м	28c. Inju Wo 1 [nyet ork?]Yes 2□		28d. Describe	how injury o	occurred	
5	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.	ry - At home, . (Specify)	, farm, stre	et, facto	ry, office			28f. Location (City or To	Street and N wn, State)	Vumber or Rura	al Route Number,
	To the Hospital within 24 hours of To the Funeral Completely filled	edicai	29a. Certifier 1 Certifying Phye (Check only one)		examinetion									
	ithin (S -	29b. Signature and title of certifier	and monitor state			29	ç. Licen:	se number			29d Date s	signed (Month,	Dey, Year)
	ř≱řő		SAMUEL Ch	AN, MI)		1)30	5651			JAN-	12;	2004
4	23		30. Name end address of person who co	mpleted cause of de	eth (Item 23)	a) (Type, f	Print)	200) H	Agen	storus	MI	2)	140
-	Stat	е	31. Dete filed (Month, Day, Year)		r's Signature	1	. 4	,		1	,			*

		•	For State Registrar		aryland / Dep	ertificate of	lealth and I	Mental Hyg	eg. No.	04 02256
T.	Physicia		Decedent's Name (First, Middle, Anthony	Frank	Grieb	٠	0	2. Date of Dea Month Jan 24,		3. Time of Death 3:38 pm M
	/Medic Examin		4a. Facility Name (If not institution, 14308 Old Lake	give street and number)	01100	4b. City, Town, o	r Location of Death	1	4c. County of Allegar	Death
	Funeral Director		212-28-4994	Sex 7. Agr 1 【XM 2 ☐ F	73 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Sep 1,	1930	. Birthplace (State or Foreign Country) MD
	aryland show dat		Usual Residence of Decedent 10a. State MD 10b. County Allect	any	10c. City, Town or I	ocation nberland				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	vith the Mi or 28a-1	Directo	10e. Street and Number 14308 Old Lake	Drive		10f. Zip Code	21502		10g. Citizen of Wh	at Country?
36	be filed within 72 hours after death with the Maryland ital Hygiene dother than "natural", or itama 23e or 28e-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.
Baltimore, Maryland 21215-0036	within 72 hou iene. then "natura the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	16a. Dec (Giv life.	redent's Usual Occup re kind of work done DO NOT use retired	pation during most of wor d)		16b. Kind of Busin	ness/Industry
land 2		To Be C	17. Father's Name (First, Middle, L Anthony J. Gr		,			ne <i>(First, Middl</i> e, eth (Basi	Maiden Sumame) I) Grieb	
Mary	nd 2 should alth and Men 27 is marke r traumatic		19a_Informant's Name/Relationsh Edna Grieb	o (Type, Print) wife	19b1Ma	iling Address (Street 308 Old La	and Number or Ru ike Drive	ral Route Numbe Cumb	r, City or Town, St. perland	MD 21502
more,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1		20b. Place of Dis cometent of Rocky Ga	position (Name of ematory or other pla p Veterans (cemetery	Date 1/28/2004	Flintstor	
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service L	7 A us	elli	^{22. Nam Scafpe 108 Vir}	#		land, MD 2	1502
P. CHILLIAN	Fnysician /Medical Examiner	er	23a. Part1. Enter the disease, or o shock for heart failure. List of the shock for heart failure. List of the shock for heart failure. List of the shock for heart failure. List of the shock failure in death) Sequentially list conditions, or any leading of the shock failure.	a. Uu Due to (or as	a consequence of):	nter the mode of dyl	ng, such as cardiad	or respiratory and	Lung	Approximate Interval Between Onset and Death
(8760,	icate be executed physicien and s the buriat-transit	ical Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):				,	
P.O. Box 6	it the death certificate t by the attending physic tached for use as the b	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	B □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date Month	
	uires that n signed by id be deta	by	Part II. Other significant condition	ns contributing to death b	out not resulting in the	underlying cause gr	ven in Part I.			ute to the cause of death?
of Vital Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed						1 Yes	med? der 2 No 1	ore autopsy findings available or to completion of cause of ath? Yes 2 No
Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpati	ient 3☐ DOA Ott	. 26. Place of Dea her: 4 ☐ Nursing H	ath (Check only of		(Specify)
	nding Phy th. : After this s funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident investig		ury 28b. Time uy Year) Injury	y Wo	ry at rk?] Yes 2 □ No	28d. Describe h	now injury occurred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could n 4 Homicide determi	and Zoo. Flace of III	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (5 City or Tow		or Rural Route Number,
	Hospital 24 hours a Funeral I letely filled	Medical C		Physician: To the best examiner: On the basis of and manner st	of examination and/or					
)	To the within 2 To the complete	Me	29b. Signature and title of certifier	what	ki		se number 054411			Month, Day, Year) - O-
	5		30. Name and address of person of Beverly Calking		death (Item 23a) (Typ	pe, Print	/Jemorial	Ave Ste 1	05 Cumb	erland MD
	St. Regist	ate rar	31. Date filed (Month, Day, Year)		rar's Signature	Land	4			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\overset{\text{Day}}{2}0,2\overset{\text{Year}}{0}4$ January **Physician** 11:16 PM GULARSKI MAY ESTHER /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🛛 F 173-16-9019 84 June 16, 1919 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County in then "naturel", or items 23e or 28e-1 show the Medical Exeminer must be notified at 1 ☐ Yes 2 X No Director Germantown Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 20874 17935 Wheatridge Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other ther any injury or other treumatic event, ILE M 2006s. 8 self dairy/convenience store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Astle Thomas Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17935 Wheatridge Drive, Germantown, MD Christine Schiff, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/23/2004 Smithsburg, Maryland 22. Name and Address of Facility Keeney and Basford Funeral Home M00999 106 East Church Street, Frede 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or learn failure. List only one cause on each line. 21. Signature of Funeral Service Licensee M00999 106 East Church Street, Frederick, MD Approximate Interval Between Ons it and Death Physician pulation 19 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☑ No P.O. 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 certificate 1 ☐ Yes 2 🛂 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PR/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel [To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) npletely 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature an tle of pertifier 8 person who complited cause of death (Item 23a) (Type, Print) 30. Name and address of Tanes and WOR CV 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2004 JAN 2 Registrar

Amended Items 25 & 27 per M.E. 01/06/2004 Carroll County, wjl Amended Item 11 per Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. F.D. 01/06/2004 Carroll Co. State of Maryland / Department of Health and Mental Hygiene wj1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marguerite P. Hunt Jan 0.34:45 am 2004 /Medical 4a. Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

Dec 07 1911 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months 1 □ M 2 🛛 F Yrs. Director 92 090-12-6520 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shouthe Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1411 Chazadale Way 21157 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐ Yes 2 ∑XNo If Yes, Give ō 1 Yes 2 XNo Specify: White Completed by 3 ☐ Widowed 4 X Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry New Home for Elementary/Secondary (0-12) College (1-4or 5+) Crippled Children Physical Therapist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Purcella Elisa Palmieri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Chazadale Way Westminster, MD Health em 27 i Irene Wheeler/sister Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 1/9/2004 | Derby, Connecticut 4 ☐ Donation 5 ☐ Other (Specify) St. Peters Cemetery 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Part* Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Dementi Examiner our lobe Prenmonia Examiner the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by t page 2 should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 X Yes Certification: To 28e. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu death. 2:36 PM Fell from Standing 2 Accident 3 ☐ Suicide 12-19-2003 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Route Number, City or Town, State) 4 Homicide Nome 1411 Chazadale Way 29a. Certifier (Check only one) rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 00051924 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

MIJI

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

State Registrar

31. Date filed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 29a) (1949) 32. Registrar's Signature

Glown & Specie

DR, Westminster, mp 21157.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** January II, 2004 DENNIS WAYNE HINCHCLIFFE 8:30 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner 800 Gabriel Court #409 Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 22, 1940 5 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 ₹ M 2 □ F 63 Canada Director Usuel Residence of Decedent Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or thems 23e or 28a-1 show eny injury or other treumatic event, the Medical France. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Frederick Maryland Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 800 Gabriel Court #409 21702 Canada Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 → Yes 2 □ No Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Yes, Give eer or Dates: Peacetime Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Artist Art 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clair Hinchcliffe Vivian Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Gabriel Court #409, Frederick, MD 21702 Dion P. Hinchcliffe (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/13/04 Smithsburg, Maryland 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licen 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiavascular Disease Examiner Due to (or as a consequence of Physician/Medical Examiner physician end s the buriel-transit or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of): use es t Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1X Yes 2 No 3 Probably 4 Unknown ete has been signed page 2 should be de Division of Vital Records, 2 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 L Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Naturel 1 Tes 2 🗆 No efter deeth. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funerel I To the Hospital 29a. Certifier (Check only one) 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner steted. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

ath (Item 23e) (Type, Print)

use of d

32. Registrer's Signature

30. Name and address of person who completed of

6 2004

31. Dete filed (Month, Day, Year)

D35164

January 12,2004

it Frederick MD 21701

			For State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of I		Mental Hygie	_ CUIII	02260
	Physici	an	Decedent's Name (First, Middle, I John	Thomas	Н	larling		2. Date of Death Month January	Pay 2004	3. Time of Death 3:30 PM
}	/Medio		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Deat		4c. County of Death	
			2890 Spring Lake			Davidso	nville		Anne Arun	
	Funeral Director		5. Social Security Number 207-20-0917	.Sex 7. A 11∏ M 2□ F	ge (In yrs. last birthday) 75 Yrs.	Months Days			ear) Cou	place (State or Foreign ntry) ISylvania
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla	ţ	Maryland Anne A	rundel	Davidson					1 ZYes 2 No
	or 28e	Directo	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Cou	ntry?
	sath w	eral I	2890 Spring Lak	es Drive	Fire in It C 12.1	21035	diamania Origina /S	Positiv Vac er No	U.S.A.	can Indian
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Modical Examination than Item official Examinations.	by Funeral	1 ☐ Never Married 2F→ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	7 1045-	f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl Specify:	to Rican, etc.)	Black, White	
Maryland 21215-0036	hin 72 ho a. "natur Mazical	Be Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	b. Kind of Business/Ir	•
7	led wit lygiene her tha	Соп	Elementary/Secondary (0-12)		Book B	inder	1 40 11 11 11		Government	
and	ld be fi ental H ked otl	To Be	17. Father's Name (First, Middle, La John Th	omas	Uamlina		Lucill	ne <i>(First, Middle, Mai</i> Le	den Sumame) Mill	er
ary	2 should and Men Is marke	1-	19a. Informant's Name/Relationship					ıral Route Number, C	ity or Town, State, Zij	Code)
S O	1 and 2 Health em 27 I		Adele Hampson/ D	aughter	/40 / 20b. Place of Dispo		n Drive,	Glenn Dale	e, Marylan c. Location - City or T	
mor	Pages nent of H nnt: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe			natory or other pla	<i>сө)</i> S 1/21		_	, Maryland
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o		21. Signature of Funeral Service Lic		22	2. Name and Addre	ess of Facility Ro	bert E. E		
	40 E 2 9		23a. Part 1. Enter the disease, or co	malications that cause				ad, Bowie		20715 Approximate
	Pnysician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a	line. TOTEL s a consequence of):	F Str	XUNSA	, or respiratory arrest,		Interval Batween Onset and Death
8760,	ficate be executed physician and is the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate asset the state of the s	c.	s a consequence of): s a consequence of):					
9	g phys as the	edlcal		d						
O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3]Ectopic pregnanc] Other (specify) _	у		23d. Date of deliv Month	ery Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobac	co use contribute to t	he cause of death? pably 4 ⊟Unknown
Il Records,	: The law requ cate has been , page 2 shouli	Completed						24a. Was an autopsy performed 1 Yes 2	prior to co	psy findings available mpletion of cause of 2 No
Vital	eician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpatien	it 3□ DOA Ott		ath <i>(Check only one)</i> Iome 5 S esidence	e Cother (Coes	
Division of	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the tuneral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, D.	ury 28b. Time of	28c. Inju	ry at	28d. Describe how i		y)
Divis	tel or Attendi s after death. el Director: A ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not determine	286. Place of in	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	the Hospitel hin 24 hours of the Funeral upletely filled	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the besi aminer: On the basis and manner s	t of my knowledge, death of examination and/or in- tated.	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
•	To the Ho within 24 To the Fu completely	Me	29b. Signature and title of certifier	agre 14	40	29c. Licens	se number	29d.	pate signed (Month,	Day, Year)
			30. Name and address of person which the Company of	o completed cause of	death (Item 23a) (Typ)	DIAMUA	Pousw	21401	1000	
	Sta Registi		31. Date filed (Month, Day, Year)	2004 32. Regist	trar's Signature	book				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Janua 004 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug 31, 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 15√m 2□ F Months Year 33 Maryland 216-28-6266 70 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Departmant of Health and Mental hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Crownsville Maryland 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 922 Johnson Grove Lane 21032 12. Was Decedent Ever in U,S. Armed Forces? 1 [X]Yes 2□ No If Yes, Give 1 9 5 0 - 5 3 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Plumber and Elementery/Secondary (0-12) College (1-4or 5+) Steamfitters 8th P1umber 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Gray William Henson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21032 19e. Informant's Name/Relationship (Type, Print) 922 Johnson Grove Lane Crownsville, Md. Mildred Henson(Wife) 20b. Place of Disposition (Name of cametery, crematory or other place)
Md. Veteran Cemetery 1/16/04 Crownsville, Md. 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility.
Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Lavry J. Teese MO0483 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Pert II. Other algnificent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 WYSS 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. I Director: A investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29b. Signature end ti 29d. Date signed (Month, Dev. Yeer) death (Item 23e) (Type, Print) s of person who completed cause 03 026 32. Reg strar's Signature 31. Dete filed (Month, Day, Yeer)

DHMH 16 Rev 6/95

State Registrar

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			For State	State of Ivid	ai y lai i	-	rtificat			uid ivid		Reg. No.	2004	02262
			Registrar 1. Decedent's Name (First, Middle, Las	t)			imour				2. Date of Dea			3. Time of Death
	Physici	an	100 /-	Lantsi	ke						Month January	13,	2004	5:00 A ^M
	/Medic		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o		,		County of Deet	
	Examir							.1:-				Ann	e Aruno	ial
	Funeral		Anne Arundel Medic 5. Social Security Number 6. Se	7. Age	e (In yrs. I	ast birthday)	Annap If Under Months	1 Year Days	If Under 2	24 Hrs.	8. Date of Birt (Month, Day	h		hplece (State or Foreign untry)
	Director		214-05-1648	^{2 M 2 □ F} 91		Yrs.	Months	Days	riodis		lug. 23		12 Mary	
	pu ,		Usual Residence of Decedent		10c Cib	r, Town or Lo	eation							10d. Inside City Limits
	anyla shov	-	Maryland Anne Arun	de1		apolis	Cation							1 ☐ Yes 2 ☑ No
	8a-f	Director		Idei	Aillic	1p0113	10f. Zip	Codo			T	10a Citiz	en of What Co	
	with 1	급	10e. Street and Number											
	s 23	era	2570 Riva Road	12. Was Decedent I	Ever in U.	S. 13.	214 Was Dece		ispanic Orio	gin? (Spec			d State	
10	ter d	필	1 Never Married 2 Married	Armed Forces?		3_				, Puèrto R	cify Yes or No- lican, etc.)		Black, White	
936	urs al	by	3 ☐ Widowed 4 ☑ Divorced	1 TYPes 2 ☐ N If Yes, Give Year or Dates:	194		1 Yes	2XNo	Specify:			;	Specify: Whi	ite
21215-0036	72 hours after death with the Maryland Inatural, or Itams 23s or 28s-f show disal Exactinational be notified at	Completed by Funeral	15. Decedent's Ed (Specify only highest gra	ucation		16a. Dece	dent's Usua	al Occupa	ation during most	t of workin	0	16b. Kin	d of Business/	Industry
21	within 7 ene. than "	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT us	se retired	j)		9			
	filed with Hygiene. Sther than	Con	11			Newsp	aper	Comp	osito	<u>r</u>	(5)		paper	
nd	d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		Sumame)	
yla	should be nd Mental marked o	ဥ	Leo C. Hantske			1					rkinso		T Co	T- 0-4-1
Maryland			James Hantske / So				_						Town, State, 2	92562
	1 and Health Inm 27 Ihar t		20a. Method of Disposition	711	20b. P	lace of Dispo			COULL		ite		ation - City or	
Baltimore,	ages or of l		1 Bunal 2 ☐ Cremation 3 ☐		C	emetery, crei	metory or o	ther plac		10010	2001			
Ħ	rtmer rtant		*4 □Donation 5 □ Other (Specify 21. Signature of Fulleral Service Zican		Crov									, Maryland ral Home, Inc.
Ba	permit. Pages 1 and 2 Department of Health s Important: If item 27 li any Injury or othar tra <u>once</u> .		M 11/1/1/	,							ter St			is, MD 21401
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death								inapo 11	Approximate
			shock, or heart failure. List only immediate Cause (Final											Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as		uence of):	UIT	,						2 munths
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	xecuted and II-transi	Examiner	that initiated events	c										
0,	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as	a conseq	uence of):								
8760	0 0	Ilcai	•	d										
x 68	certificat nding phy use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of propps	nov.								
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	death 3	☐Ectopic p					2	3d. Date of del Month	Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or d	eath 3	_ Other (sp	Decity/						
4	that the ed by detac	H.	Part II. Other significant conditions c	ontributing to death b	ut not res	ulting in the u	inderlying o	ause giv	en in Part I.		23e. Did to	obacco us	e contribute to	the cause of death?
sp	law requires that as been signed b 2 should be deta	d by									101	es 2	No 3□Pr	obably 4 Hinknown
Ö	beer shou	iete									24a. Was	an	24b. Were au	itopsy findings available
Re	The la	Completed										rmed? 2 ☑ No	death?	completion of cause of
of Vital Records,	sician: The law certificate has b irector, page 2 s	e C	25. Was case referred to medical						26. Place	of Death	(Check only o		1 1 1 1 1 1 1 1 1	21110
>		0.8	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2	ER/Outpatier	nt 3 D0	Oth Oth					□Other (Spe	cify)
101		n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju	ry v Year)	28b. Time o	of 2	28c. Injun	y at		8d. Describe			
ior	Attending or death. ector: After by the fune	atio	2 ☐ Accident investigation	1		,.	М		Yes 2	No				
Division	r Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj			reet, factor	y, office		2	8f. Location (S City or Tox	Street and vn, State)	Number or Ru	ural Route Number,
Q	urs af ref D	S			, .									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical		ysician: To the best niner: On the basis o and manner st	of my kno f examina	wledge, deat tion and/or in	th occurred evestigation	at the tin i, in my o	ne, date an pinion, dea	th occurre	d at the time,	date and	and manner as place, and due	s stated. to the cause(s)
	thin 2 of the	Mec	29b. Signature and title of ceptifier,	1 10	a		29	c. Licens	e number			29d. Date	signed (Mont	h. Day, Year)
	ĕ ∓ ĕ ĕ		Massh	all			()5	181	9		11	13/	44
			30. Name and address of person who	completed cause of a	jeath (Iten	n 23a) (Type.	, Print)					. /		
			Matthew J.	mx /tg	13	2 Ho	1. c/c	5	+	Scite	VS J	/ /	anner	1. J.
25	St	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	iture								
	29a. Certifier (Check only 2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 5 2004													

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 0421 AM ANUARY 10 2004 HITE Dorothy Louise /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown Hagers Lowin

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 30, 1920 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Pennsylvania 1 □ M 2 🖾 F 83 Yrs. 183-12-3470 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "nstural", or Itams 23s or 28s-f show Its Medical Examiner must be notified at Hagerstown 1 Yes 2 No Maryland Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 1015 Linwood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) her own home 0 - 12homemaker 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth, any injury or other traumatic svent, once. 17. Father's Name (First, Middle, Last) Be Mary Bohl John B. Cool 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12040 Mayfair Avenue, Hagerstown, Maryland 21742 Sandra Busey - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Memorial Park 14,2004 Williamsport, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home / Lenne 15 East Wilson Blvd., Hagerstown, Maryland 2174 23a. Part1. Enter the disease, or complications that oaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 48 har **Physician** /Medical Due to (or as a consequence of): Examiner Jacline Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit nemoma attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death page 2 should be detached 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No certificate has 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospitel or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D28365 1-10-04 WW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 Mills street Hagerstourn 19 021740 HAFI MANZAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Specia Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gertrude Edith Hall ANUAY-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** UNIVERSIL Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 17, 1 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 428-66-0470 Vrs 1919 North Carolina Director 84 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h Counts 10c. City, Town or Location traumatic ayant, the Madical Examiner must be notified at 1 XYes 2 □ No MD Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1402 Cambridge Beltway 21613 Be Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) state government 11 supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of should be Charlie Eugene Crabtree Mattie Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas M. Ridley 308 Oakley St., Cambridge, MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Salisbury Crematory * 4 ☐ Donation * 5 ☐ Other (Specify) 1/7/04 Salisbury, MD 21. Signatu Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner THE CALL IN APPROVED ... MEDICA use as the burial-transit Hospitel or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Bridge 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No caused Odoutois 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 2 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 □ Natural 5 Pending investigation Injury fellat of 103 2 Accident 3 ☐ Suicide ULLUCW_M after death. 11 filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 402 within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person

J.N. W.Z.A.R. (Month, Day, Year)

JAN 12

Balfinere, MD 21250

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

601

MD

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		•	for State Registrar	orace or marytant		te of Death	Reg. N	- 4004	02265
	Dharaini		1. Decedent's Name (First, Middle, La	st)			2. Date of Death Month JANUARY	Day Year	3. Time of Death
	Physicia /Medic		Dorothy ANN,	1 Heath					
	Examin	er	4a. Facility Name (If hot institution, gives Saint Joseph	Medical Cen		, Town, or Location of Dea	son	4c. County of Death Ball	timore
	Funeral	1	Social Security Number 6.5		ast birthday) If Under	er 1 Year If Under 24 Hr		9. Birth	place (State or Foreign
A.	Director		060-27-0122	10 M 2 MF 72	Yrs.	Days House	8-21-1	931 Ne	2.3
	land low		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
•	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exercises must be notified at injury or other traumatic.	ctor	Maryland Har Fo	ord Ab	perdeen,				1 Yes 2 No
	with th	Directo	10e. Street and Number	C+ 1.+ 111	10f. 2	ip Code	10g. 6	Citizen of What Cou	intry?
	ns 234	eral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Was Dec	adent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ameri	
9	or Item	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, sp	ecify Cuban, Mexican, Pue	erto Rican, etc.)	Black, White,	, etc.
003	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:	16a. Decedent's Us	/	126	Kind of Business/Ir	Mite
Maryland 21215-0036	in 72 n "nat	Completed by	15. Decedent's E (Specify only highest gi	ade completed)	(Give kind of w life, DO NOT	ork done during most of w		Killa di Dasillessa	ladsity
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ryla	should be and Mental marked c	ို	19a, Informant's Name/Relationship	Thoude	19h Mailing Addre	ss (Street and Number or	Flizabeth Bural Boute Number, Cit	v or Town, State, Zi	in Code)
Z	and 2 sho salth and n 27 le m		San Ara Main	-dauahter	6651	FIM ST	Aberdee	0.00	21001
ore,	of Hear item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [() 20b. P	lace of Disposition (Nemetery, crematory or	ame of other place)	Date 20c.	Location - City or T	own, State
Ē	Pages ment of ant: If it		* 4 □ Donation 5 □ Other (Spec	(v) KAT	trris Com	Dany 1-2	10-2004 W.	est Chester	YA
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr QDCS.		21. Signature of Funeral Service Lice	nsee 12/2/2/28	22. 7 0%	dad less of Eacility	to tuneral	dome,	21001
			23a. Part1. Enter the disease, or cor	aplications that caused the death	n. Do not enter the ma	ode of dying, such as card	ac or respiratory arrest,	ev, I'd	Approximate Interval Between
8	Physician		shock, or heart failure. List ont Immediate Cause (Final disease or condition	a END STAGE CHR	ONTO ORSTI	DUCTIVE PULM	ONARY DISEAS	SE	Onset and Death
6.a	/Medical Examiner		resulting in death)	Due to (or as a consequ		0011,2 1021			
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	CORONARY		ISEASE		1	
oʻ	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequ		TTIIC			
8760	y s	dical		d. TYPE 2 DI	CABETES N	IELL ITUS			
89 x	the death certifica y the attending ph Iched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of deliv	/ery
Box	death e atter	Iclar	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de				Month	Day Year
P.0	that the de ed by the detached	Phys	9 🗆 Unknown		ar Taran a stan		23a Did tabasa	co use contribute to	the sauce of death?
	es be	by	Part II. Other significant conditions HYPERTENSION	contributing to seath but not rest	niling in the underlying	cause given in Fatti.	1 💢 Yes		bably 4 Unknown
COL	w requii	lete	SEVERE OSTEOARTH	RITIS OF KNEES	AND HTP		24a. Was an	24b. Were aut	opsy findings available
Vital Records,	The lav ate has page 2	Completed	SEVERE OSIEGIRIII	KITID OF KINDE			autopsy performed	? death?	ompletion of cause of
ital		Be C	25. Was case referred to medical examiner?				eath (Check only one)		
of V	S S	2	1 ☐ Yes 2 💢 No	Hospital: 1 Inpatient 2			Home 5 Residence		ity)
	ing Yfter une	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \)	28d. Describe now ii	ijury occurred	
Division	at at	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 380 Place of Injury - At ho		ory, office	28f. Location (Street City or Town, St	and Number or Rui	ral Route Number,
Ö	ital or	Cert							
~	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	owledge, death occurrention and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ice, and due to the cause curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	And married stated.	2	9c. License number		Date signed (Month	
	- > - 0) (oballo	my		D 25886	5	an.18	-2004
	2		30. Name and address of person wh						
	U	ate	31. Date filed (Month, Day, Year)	05. M. D. 761 32. Begistrar's Signa		DRIVE, TO	WSON, MAR'	YLAND 21	<u>CV4</u>
á	Regist			2004	13 Forest	· p ·			

			For State Registrar	State of Marylar			of Health of Dea			giene Reg. No.	200	022	56
	Physicia /Medic		1. Decedent's Name (First, Middle, Lass Robert Evans Illi					1_	2. Date of Dea Month	Day	Year 2004	3. Time of Death	М
)	Examin Funeral Director	er	4a. Facility Name (If not institution, give 120 Dogwood Court 5. Social Security Number 6. Se 186-24-0336		. last birthday) Yrs.	Mill If Under 1	ington Typer If United Days Hour	der 24 Hrs.	B. Date of Birt (Month, Da	th y, Year)	Queen Position of Deat Position Property of Deat Position Property of Deat Position Property of Deat Position Property of Deat Position Property of Deat Position Property of Deat Position Property of Deat Position Property of Deat Property of D		<i>ig</i> n
	D	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Queen An	10c. C	ity, Town or L Milli		Code				en of What Co	10d. Inside City Lim	its
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene than "naturel", or Reme 23a or 28a-f ehow other than "naturel", or Remirat routi be notified at event, the Medical Examinat routi be notified at	by Funeral Directo	120 Dogwood Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 12Yes 2 ☐ No If Yes, Give Year or Dates:	J.S. 13.		21651 ent of Hispanic fly Cuban, Mex			USA	I. Race - Ame Black, White	rican Indian,	
21215-0036	within 72 ene. than "na!	Completed b	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	DO NOT use	k done during r e retired)			trans	of Business/		
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, III	To Be	17. Father's Name (First, Middle, Last) George Washington 19a. thformant's Name/Relationship (7)		19b. Mail	ing Address		other's Name (lorence mber or Rural	Cantw	ell		Zip Code)	
Baltimore, Ma	1 and Health Iom 27		Josephine Illingsw 20a. Method of Disposition 15 Burial 2 Cremation 3 Company 4 Donation 5 Other (Specify	20b. Removal from State	120 Place of Disposemetery, creampton	osition (Nam matory or oti	her place)	De		20c. Loca	ation - City or		
Balti	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licen August 1112 23a. Part 1. Enter the disease, or comp	,	F. 3	ellows 70 W.	Address of Fa Helfe Cypress	enbein Stree	& Newn t, Mil	am Fu lingt		Home, P.A ryland 21	6 51
8760,	Physician /Medical Examiner parial-transit		Shock, or heart failure. List only of the control o	b. Due to (or as a conse	quence of):							Interval Between Onset and Peath	
O. Box 6	The law requires that the death certificat ite has been signed by the attending phypage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tel death 3	□Ectopic pre				23	3d. Date of del Month	ivery Day Year	
Records, P.	v requires that the de been signed by the a should be detached f	by	Part tl. Other significant conditions of	ontributing to death but not re	sulting in the	underlying ca	ause given in P	art I.	1	obacco us Yes 2 🗆		the cause of death?	
	iiclan: The law i certificate has b rector, page 2 sh	Completed	25. Was case referred to medical				06.8	Uses of Death		psy prmed? 200 No	24b. Were au prior to death? 1 \(\sum \text{Yes}	utopsy findings availa completion of cause	ble of
Division of Vital	ding Phys	atlon: To Be	examiner? 1 Yes 2 No 27. Manner of Death Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie		Othor			dence 6	Other (Spe	cify)	
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Specials)	eiry)				City or To	wn, State)		ural Route Number,	
)	To the Ho within 24 I To the Fu completely	Medical	29b. Signature and title ocertifier	and manner stated.	<u>. v</u>	D D	License numb	0301		29d. Date	signed (Mont		
	Sta	ate	30. Name and address of person who MICHESE 16 17 31. Date filed (Month, Day, Year) 20	completed cause of death (literated in the cause of death (literat	em 23a) (Type SKHW nature	Print)	5785	CH e s.	orta	יאט, א	MAY 9	1620	
	Regist		3AN 1 4 20	The same	O R	34							

		1	For State Registrar	State o	f Marylar		artment rtificate					giene Reg. No. 2	004	02267
		_	1. Decedent's Name (First, Middle,	ast)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Patricia An	n IS	ON						Januar		2004	11 05 A ^M
	Examin		4a. Facility Name (If not institution, g	ive street and nu	mber)	-	4b. City,		Location of	of Death		4c. Cot	unty of Deat	th
			Cuppett Weeks N	ursing H					land	O4 Usa			rett	
	Funeral Director		219-380968	.Sex 1 ☐ M 2 🂢 F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Dec. 1	y, Year)	9. Bin Co Mar	thplace (State or Foreign ountry) yland
	po v	-	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	sho	5						т "1. "	D =1	ı_				1 ∏ Yes 2 ☐ No
	28a-f	Director	MD Ga 10e. Street and Number	rrett	1	Moun	tain 10f.Zip		Pari	К		10g. Citizen	of What Co	ountry?
	with or	ā	506 E Street					21	.550				USA	
	eath	2	11. Marital Status		edent Ever in t	J.S. 13.	Was Deced			igin? (Spe	ecify Yes or No Rican, etc.))- 14.	Race - Ame	erican Indian,
	r Iter	돌	1 X Never Married 2 Marrie	Armed F	2 🕅 No						Hican, etc.)		Black, Whit	le, etc.
ဗ္ဗ	al', o	δ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or [oates:		1 ☐ Yes	ZIŽĮ NO	Specify:			Spi	ecity: Wh	nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or Items 23a or 28a-f show sht, it e Medical Examiliner must be motified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usua kind of wor DO NOT us	d Occup	ation during mos	st of worki	ing	16b. Kind o	of Business	/Industry
7	ithin	npid	Elementary/Secondary (0-12)		(1-4or 5+)							TT	7.1. 0	
7	ygier ygier her th	S	12			неал	th Ca	re w			(First, Middle		lth C	are
Ē	be fill	Be	17. Father's Name (First, Middle, La		D									
3	d Mer narke	ပ္	Gorman Benji 19a. Informant's Name/Relationshi		Bowsei		ing Address	(Street		augh er or Bura	LO Il Route Numb	rida er. City or To	Ha wn, State,	
Maryland	d 2 st th and 7 is n traun		Melva Jane Bows		r						e Park			21550
	1 and Healt em 2		20a. Method of Disposition			Place of Disp	osition (Nar	ne of			Date			Town, State
ē	ages nt of t: if it		1 ☑ Burial 2 ☐ Cremation 3		State De	cemetery, cre eer Par				1/1	6/04	Deer	Park	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-1 show any injury or other traumatic avent, it e Medical Examination ust be notified at once.		21. Signature of Fureral Service, Li		0		2. Name an				ewart			
Ba	permi Depa Impo any i		Brown H	THOUSE	7	3	2 S.	Seco	nd St		akland			21550
			23a. Part1. Enter the disease, or c	omplications that	caused the dea	ath. Do not en	iter the mod	e of dyir	ng, such as	cardiac o	or respiratory a	ırrest,		Approximate Interval Between
Н	Dhysisian		shock, or heart failure. List o Immediate Cause (Final											Onset and Death 3 months
н	Physician /Medical		disease or condition resulting in death)		nocarci		HIKHOV	vn p	rimar	y sı	re			J MOTTETIS
	Examiner			Meta	astasis	to Li	ver							2 months
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a conse	equence of):								
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	c										
oʻ	ate be executed hysician and the burial-transit	Ä	resulting in death) Last	Due to	o (or as a conse	equence of):								
3760,	ate be hysic the bu	lical	3	d										
K 68	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:	220 If yes o	utoome of pred	nancy						224	Date of de	livea.
Box	eath ce attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	utcome of preg birth 2 Te gnant at time of	tal death 3	□Ectopic p		у			230	. Date of de Month	Day Year
o.	at the de. by the a reached f	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unk		dealii 5	□ Ottlet (s)	Decity)_						
<u>α</u>	that the ed by detac	P	Part II, Other significant condition	s contributing to	death but not re	esulting in the	underlying o	ause gr	en in Part	l.	23e. Did	tobacco use	contribute t	to the cause of death?
ds,	signe d be	d by									1 🗆	Yes 2□N	4o, 3 □ P	robably 4 XUnknown
Vital Records,	The law requires that tte has been signed b page 2 should be deta	Completed									24a. Was	san 2	24b. Were a	utopsy findings available
Re	The lav	E C										ormed?	death?	completion of cause of s 2□ No
<u>_</u>		ပိ	25. Was case referred to medical						26 Plac	e of Deat	1 ☐ Yes	2X No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5 2 140
₹	sicia cer rect	00	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 Do	OH Ott	ner		me 5□Res		Other (Spe	ecify)
of		n: To	27. Manner of Death	28a, Dat	e of Injury onth, Day Year)	28b. Time		28c. Inju	ry at		28d. Describe	how injury o	ccurred	
ion	Attending I ir death. ector: After by the funer	ig i	1 X Natural 5 ☐ Pending 2 ☐ Accident investig.		intii, Day 16ai)	Injury	М		Yes 2	No				
Division	or Attendeath efter death Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	206. Fla	ce of Injury - At Iding, etc. (Spe	home, farm, s	treet, factor	y, office				(Street and Nown, State)	lumber or F	Rural Route Number,
Ö	rs efter ral Directed in by	Ç								1				
	To the Hospital or At within 24 hours efter or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 X Certifying (Check only 2 Medical E	Physician: To to xaminer: On the and ma	he best of my k basis of exami anner stated.	nowledge, dea nation and/or i	ith occurred investigation	at the ti	me, date a opinion, de	ath occur	and due to the red at the time	date and pla	ace, and du	e to the cause(s)
	To the within 2. To the I	₩	29b. Signature and title of certifier	^		01	29	c. Licen:	se number			29d. Date s	igned (Mon	nth, Day, Year)
•	- >- 0		John Mans	Jann	AM			I	12615	4			1/15/	2004
	5		30. Name and address of person v	no completed ca	use of death (I	tem 23a) (Type	e, Print)							
	3		Dr P Daniel	Miller	DO 6	9 Wolf		Dr	ive (0akla	and Ma	ryland	215	50
	St Regist	ate	31. Date liled (Month, Day, Year)	6 2004	Registrar's Sig							-		

		1	For State Ragistrar	State of Maryland		artment <i>tificate</i>				Rag	-	2004	02	268
	Diam'r.		1. Decedent's Name (First, Middle, Last)					2. Date Mor		Day	Year	3. Time of	
	Physicia /Medic	al	Carroll Henry						Jai	n.		2004	3:02	РМ
-	Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or Lo					nty of Death		
			2022 Suffolk Ro			If Under	Fink	sbur; fUnder 2		· · (Dia)		Carrol		- Consists
	Funeral	- 1	5. Social Security Number 6. Se 215–34–7023		ast birthday) 65 Yrs.	Months		Hours	Min. (Mo	e of Birth nth, Day, Y	193	9. Birting Coun	lace (State of	
	Director	-	Usual Residence of Decedent		٠٠٠. رن				Sep	t. 7,	1930	o ria	ryland	1
	and		10a. State 10b. County	10c. City	, Town or Lo	cation						1	0d. Inside C	ity Limits
	Mary f sh	ō	Maryland Carroll		Finl	ksburg	יכ						1 🗌 Yes	\$⊡kNo
	128e	Director	10e. Street and Number			10f. Zip				10g	. Citizen o	of What Cour	ntry?	
	38.0		2022 Suffolk Roa	.d			21	048		τ	Jnite	d Stat	ces	
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Deced	ent of Hisp	anic Orig	gin? (Specify Ye , Puerto Rican, e	s or No-		lace - Americ		
9	or Ite	F	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 🔯 No	1	1 ☐ Yes 2			,		}	^{cify:} Whi		
21215-0036	within 72 hours after death with the Maryland ene. Than "heturel", or Items 23a or 28e-f show he Madical Exarting court be motified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:						1				
ς. Υ	72 h "nett	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usua kind of wor	l Occupation k done dur	on ring most	of working	16	b. Kind of	Business/In	Co11	ege
2	within ne. han	E D	Etementary/Secondary (0-12) 8th	College (1-4or 5+)		ecuri				Ca	arro1	1 Com		_
7	Hygie Hygie Ither nt,	ပိ	17. Father's Name (First, Middle, Last)						r's Name (First,					
au	ntai ed o	9 Be	James Carro	11 Gamber				K	atherin	e F	Johns	son		
Maryland	thoulk id Me mark matik	ဥ	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address	(Street and		r or Rural Route				Code)	
<u> </u>	th ar		Cheryl Marie Gibb		353	7 Rid	ge Ro	ad	Westmins	ster,	MD	21157		
ē,	Hea Hea tem		20a. Method of Disposition	20b. P	lace of Dispo emetery, crer	sition (Nan	ne of	I	Date	20	c. Locatio	n - City or To	own, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturely, or liems 23a or 28e-f show amy rightry or other treumatic event, the Madical Examples must be notified at any rightry or other treumatic event, the Madical Examples must be notified at ances.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State				y J	an. 14,	2004	Ham	pstead	l, Mar	y1and
≣	artin orter injur	- 4	21. Signature of Funeral Service Licen		22	2. Name an	d Address	of Facility	у			·		
ä	Depa Impo any i		Janey 1	Cauun	Bi	urrie: 212 W	r-Que	en F	uneral l erty Roa	Direct	ors, Infie	ld, M	217	84
	Application and Margin	Examiner	23a. Part 1 Enter the disease, or compshox, or heart failure. List only of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the death one cause on each light of the death one cause on each light one cause on each light one cause on each light one consequence of the death one cause of the death one cause of the death one cause of the death of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause of the death one cause on each light one cause on each light one cause of the death one cause of the death one cause on each light one cause on each light one cause on each light one cause on each light one cause on each light one cause on each light one cause on each light one cause on each light one cause on each light one cause on each light one cause of the death one cause of the deat	uence of):	er the mod	e of dying,	Such as	cardiac or respir	ratory arres	V 2 3	50	Approximal Interval Bei Onset and	ter tween Death On H.S
8760,	ate be hysici the bu	lcal		. d										
.O. Box 68	he death certifica / the attending ph ched for use as tf	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3[⊒Ectopic pr ⊒ Other <i>(sp</i>						Date of delive Month	,	Year
<u>α</u>	w requires that the death been signed by the atte should be detached for	δ	Part II. Other significant conditions of	ontributing to death but not rest	ulting in the u		ause given	in Part I.	. 23	e. Did toba 1 ☐ Yes	-/	ontribute to the	he cause of coably 4	
of Vital Records,	e tar has je 2	Completed	Hyperte	s mellit	eg	+1	26	77_		a. Was an autopsy performe	24 d?	b. Were auto prior to co death? 1 \(\sum Yes		available cause of
ita		Be C	25. Was case referred to medical					26. Ptace	of Death (Chec	k only one)				
~	Physicien: rthis certific ral director,	2	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DC	Other	4 □ Nu	rsing Home 5				fy)	
0 0	nding Physicien: th. : After this certifica s funeral director, i		27. Manner of Death Satural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury		28c. Injury a Work?			escribe how	injury oc	curred		
<u>S</u>	Attending or death. ector: After by the fune	atle	2 Accident investigation			М		es 2 🗌					al Causa Mus	
Division	her de direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif		reet, factor	y, office			by or Town,		imber or Rura	ar Houte rvur	nber,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	ledical Ce	29a. Certifier Certifying Ph	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred evestigation	at the time	, date an nion, dea	nd place, and du th occurred at th	e to the cau ne time, dat	se(s) and e and plac	manner as s	stated. o the cause(s)
	o the lithin 2 o the o the xmple	Med	29b. Signature and title of certifier	/ state of state of		29	c. License	number		290	1. Date sig	gned (Month,	Day, Year)	
	F 3 F 8	i	Noyan	vopule 1	MID		05	34	42	1	112	104		
,	WSZ		30. Name and address of person who	completed cause of death (iter	n 23a) (Type 3 Q (H	Print)	re l	31V	d u	iest M	MI	NS +0	7	
	St Regist	ate rar	31. Date fited (Month, Day, Year) JAN 1 2	32. Registrar's Signation 2004	ature	Sner	No.							

		•	For 1 State Registrar	State of Mai	ryland /		tment of H		and M		iene _{eg. No.} 2 (04	02	269
			Decedent's Name (First, Middle, Last)							2. Date of Deal	th Day	Year	3. Time o	f Death
	Physicia /Medic		Walter Arthur	Jones						January		004	2:55	A M
	Examin		4a. Facility Name (If not institution, give str	eet and number)		4	b. City, Town, or	Location of	of Death		4c. County			
		₫3	1634 Oldtown Rd.				Edgew		0411-0			Arur		
4	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Dey Aug. 16	, 1926	9. Birth	place (State intry) hingto	or Foreign
	Director		579-32-4465 Usual Residence of Decedent		77					Aug. 16	, 1920	was	minge	JII, DC
	land •••		10a. State 10b. County		10c. City, Tox	wn or Loca	ition						10d. Inside C	
	Man,	tor	Maryland Anne Aru	ndel	Ed	lgewat	er						1 🗆 Yes	2 → No
	n the	Directo	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Cou	intry?	
	23a c	rai	1634 Oldtown Rd.				210				US			
	tems er n	Funerai	1. Individuo oraceo	2. Was Decedent Ev Armed Forces?		13. Wa	as Decedent of H res, specify Cuba	ispanic Ori in, Mexicar	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)	14. Ha	ce - Amen ck, White,	ican Indian, , etc.	
20	s afte	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	0	10	∃Yes 2XXNo	Specify:			Specia	y: Wh	ite	
9500-61212	be filed within 72 hours after death with the Maryland the black of the black of other than "natural" or items 23a or 28a-f show dother than "natural" or items 23a or 28a-f show avent, I to Medical Evaluinar mant be nedified at		15. Decedent's Educa	ation	168	a. Decede	nt's Usual Occup	ation			16b. Kind of 8			
<u>ლ</u>	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+	-)	lite. DC	nd of work done NOT use retired	during mos d)	t of worki	ng				
	d with giene ar the	Com	10th			Par	er Cutt					Prin	ting_	
<u> </u>	2 4 2 2	Be (17. Father's Name (First, Middle, Last)							(First, Middle,		ne)		
Maryland	should be ind Mental marked c	2 L	Harry S. Jon							a Amelia				
<u>a</u>	2 shot and is m	1.7	19a. Informant's Name/Relationship (Typer Henrietta A. Jones/		19		Address (Street Oldtown						p Code)	
	ss 1 and 2 should to of Health and Ment of Itam 27 is marked r other traumatic		20a. Method of Disposition	WIIC	20b. Place		tion (Name of tory or other place				20c. Location		own, Stete	
وّ	Pages nent of h int: if ltu iry or of		1 ☐ Burial 2 【Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State			itory`or other plac ematory		-14-		Edgewa			
Baltimore,	permit. Pages Department of I Important: If Its any injury or o		21. Signature of Funeral Service Licenses		Nais		Name and Addre							me.
Ra	impo impo eny		Vallatellate-			29	73 Solom	ons I	slan	d Rd. E	dgewate	er, M	D 2103	17
Н	- 25		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to	the death. Do	o not enter	the mode of dyir	ng, such as	cardiac o	r respiratory arr	est,		Approxima Interval Be	tween
***	Physician		Immediate Cause (Final disease or condition	1 1	VG- (And	e.R					•	20 UU	Death NATH
2 }	/Medical		resulting in death)	Due to (or as a	consequence	e of):	~							
1	Examiner	L	Sequentially list conditions, b.	Photograph Colored to		or selfe.								
	ed isit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	Leonsoquene	10 Oty.								
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760,	ie be executed ysicien and e burial-transit	calE	d											
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Вох	leath certifica attending ph I for use as th	N/U	23b. was decedent pregnant	c. If yes, outcome o		ıth 3⊟E	ctopic pregnancy	,				ate of deliv	very Day	Year
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	in the past 12 months? 1 Yes 2 No	4☐Pregnant at t 9☐Unknown			Other (specify)				IV)	onth	Day	1001
P.0	that the de ted by the a detached	Phy	9 Unknown Part II. Other significent conditions cont	ributing to death but	t not resulting	n in the unc	lerhing cause on	en in Part I		23e. Did to	bacco use con	tribute to	the cause of	death?
	w requires that been signed to should be det	t by	Part II. Other significent conditions con	nouning to doubt bu	t riot rosatting	g in the and	iony mg occord give	0.1	•	to €			bably 4	
Ö	need	Completed								24a. Was a	24h	Ware aut	opsy findings	s available
Vital Records,	has by ge 2 s	mpl						_		autop: perfor	nped/2	prior to co death?	ompletion of	cause of
a			OS Man annual to made a					00 Diag	a of Dooth		2 No	1 🗆 Yes	2 No	
	aicia certi irecto	o Be	25. Was case referred to medical examiner?	ospital:	nt 2□FB/0	Outpatient	3 DOA OU			n <i>(Check only or</i> me 5 x Resid		her (Spec	ifv)	
Division of	ਜ਼ ਦੇ ਜ਼	⊢	27. Manner of Death	28a. Date of Injun (Month, Day	v 28b	. Time of	28c. Injui Woo	y at		28d. Describe h				
<u>o</u>	Attending Ph er death. actor: After th by the funeral	atio	1 Natural 5 Pending 2 Accident investigation	(Worth, Day	1 Gai)	Injury		Yes 2	No					
ΝİS	er de racto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, . (Specify)	farm, stree	et, factory, office			28f. Location (S City or Tow		ber or Rui	ral Route Nu	mber,
	ital or ral Di													
	To the Hospital or Attending I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Medical	29a. Certifier Certifying Phys (Check only one)		examination a									(s)
	thin 2 this tha mplet	Med	29b. Signature and the of terrifie	and manner stat		·	29c. Licens	e number		- 2	29d. Date sign	Month	, Day, Year)	
	F 3 F 8		1 John Can	RO MAR)		DII	26.	4		11/2	104	1	
			30. Name and address of person who cor	np eted cause of de	eath (Item 23a	a) (Type, P	rint)	000	1		VIVA	10	7	
			Peter R. Graze				Rd., St	ite 3	300.	Annapol	is. MD	2140)1	
		ate	31. Date filed (Month, Day, Year) JAN 1 5 200	32. Sigistra	r's Signature	175	and a		,	3.5	_~,			
	Regist	rar	JAME T 9 ZUL	77	A LA	100	BAR I							

		1	For Stata Ragistrar	State o	f Marylan	•	rtment <i>tificate</i>			Mental H	ygiene Rag. No.	2004	02270
			Decedent's Name (First, Middle, Last)				_			2. Date of E	eath Day	/ Year	3. Time of Death
	/sicia		Edwin Franklin JOH	NSON						Januar	-		12:00 p ^M .
	ledic: amine		la. Facility Name (If not institution, give st	reet and nur	mber)		4b. City, To	own, or L	ocation of De	ath	4c.	County of Deat	1
			Beverly Health Ca	re			Н	_	stown			Washing	gton
Fund			5. Social Security Number 6. Sex 1 🖔	M 2□F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months		If Under 24 H Hours Mi	rs. 8. Date of E in. (Month, I March	Da <i>y</i> , Ye <i>ar</i>)	9. Birti Co 07 Man	nplace (State or Foreign untry) :yland
			Usual Residence of Decedent										
rylan	3	. 1	10a. State 10b. County		10c. City	, Town or Lo							10d. Inside City Limits 1 XYes 2 No
e Ma	1	5	Maryland Washin	gton		Hage	erstow						
death with the Maryland ms 23a or 28a-f show	Den	Director	10e. Street and Number 308 Bentley Court				10f. Zip C	2174	.0			izen of What Co SA	untry?
eath	9	era			edent Ever in U.	S. 13. V	Vas Decede	nt of Hist	anic Origin?	(Specify Yes or I	10-	14. Race - Ame	
_ <u>a</u> <u>a</u>	animer.	by Funeral	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	orces? 2 2 No ve	ŀ	fYes,specif □Yes 2	fy Cuban,	Mexican, Pu Specify:	èrto Rican, etc.)		Black, White Specify: V	e, etc. vhite
15-UUSO 72 hours af "natural", or	띎		15. Decedent's Educ			16a. Deced	lent's Usual	Occupati	on		16b. K	ind of Business/	Industry
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withir lene.	The M	Ē	Elementary/Secondary (0-12)	College (1	1-40r 5+)	qual:	ity co	ntro	1		a	ircraft	
# ₹£		BeC	17. Father's Name (First, Middle, Last)					1	8. Mother's N	lame (First, Midd	le, Maiden	Sumame)	
- 2 a -	Š.	10 B	Benjamin F. Johnson	n					Cora N	leedy			
	umatic		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	g Address (Street an	d Number or	Rural Route Num	ber, City o	or Town, State, 2	(ip Code)
Z 27 1	rtra		Michael Johnson -	nepher	W	1611	Dua1	High	way, E	lagerstov	m, M	d. 2174	0
ore, Mary ss 1 and 2 sho of Health and I litam 27 Is ma	oth	18	20a. Method of Disposition		C	lace of Dispo	sition (Name	e of ner place)		Date	20c. Lo	ocation - City or	Town, State
Page ento	ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from	State	est Ha	-			10/04	Ha	gerstown	n, Maryland
Baltimore, permit. Pages 1 ar Department of Hea	in e		21. Signature of Funeral Service License	nn	. /) 22	. Name and	Address	of Facility	MINNI	CH FU	NERAL H	OME
n gae	£ 9		SCOU !!	11/1/6	sund		415 E.	Wil	son Bl	vd., Hay	gerst	own, Md	. 21740
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ortifica no pl	ast		IF FEMALE:										
BOX eath cer attendin	or use	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregna birth 2 ☐ Feta	Ideath 3	Ectopic pre					23d. Date of del Month	very Day Year
o deal	bed fc	Sici	1 Yes 2 No	4□Pregr 9□Unkn	nant at time of di lown	eath 5□	Other (spe	cify)			-		
P.O. BOX 6 that the death certif ed by the attending	etacl	by Physician/Me	Part II. Other significant conditions con	tributing to d	loath but not rec	ulting in the u	nderhina ca	use awar	in Part I	23e Di	d tobacco i	use contribute to	the cause of death?
VISION Of VITAI RECONDS, P.O. BOX 68/6U, Attanding Physician: The law requires that the death certificate be executed reach: actor: After this certificate has been signed by the attending physician and	0	þ	Part II, Other significant conditions con	tabutang to d	Balli Bul Hot 145	ulting in the u	nderlying car	uso givoi	inii aiti.			□No 3□Pr	
Vital Records, sicien: The law requires t certificate has been signe	should	Completed								-		1	
e law	N	횬									topsy rformed?	prior to death?	topsy findings available completion of cause of
The true	, pag									1 ☐ Yes	2 No		2 No
Vital Fician: The Certificate	ector	Be	25. Was case referred to medical examiner?	ospital:						Death (Check onl			
Of Phys	al dir	2	1 ☐ Yes 2 ☒ No	28a. Date		ER/Outpatier 28b. Time o		A Inuiv	4 Nursin	g Home 5 ☐ Re 28d. Describ			city)
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Division of lor Attanding Physatter death. Diractor: After this	d ni b	Certification;	4 ☐ Homicide determined	build	ling, etc. (Specif	y)	,			City or 1	own, State	9)	
Division To the Hospital or Attanding I within 24 hours after death. To the Funaral Director: After	completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ner: On the b									
thin 2	omple	Mec					29c.	License	number		29d. Da	te signed (Mont	h, Day, Year)
184	ō) found or	mhu	1		7	000	039	6	1	710	4
,5			30. Name and address of person who co	mpleted cau	se of death (Item	n 23a) (Tvna	Print)		,			1 1 1	71741
3			FARIO 1	NUN	SHE	D	4120	. (OPEI	(041	+ H	sers tuc	n mp
Re	Sta egistr		31. Date filed (Month) Park Year) 9 20	04 32.	registrar's Signa	aturis A	odefield			(ou/			

			. For	State of Maryland						000=
		•	1 - State Registrar		Ce	rtificate of	Death	Reg	. No. 4 U U	+ 02271
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		Louise	Knowles_				January1		
	Examin		4a. Facility Name (If not institution, give				or Location of Deat	h	4c. County of De	
			Frederick Memori				erick		Frederi	
4.	Funeral Director		5. Social Security Number 6. S 214-64-5075	92 7. Age (In yrs. Ia	st birthday, Yrs.	Months Days				rthplace (State or Foreign country) aryland
	pue »		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or L	ocation				10d. Inside City Limits
	should be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural, or liems 23a or 28e-f show marked other than "natural, or liems 24a or 28e-f show marked other ham "natural per notified at imate ovent, the Medical Exural natural per notified at	ō		C	homob					1 ☐ Yes 2 📉 No
	the h	Director	Maryland Montgome	ery Galt	hersb	10f. Zip Code		109	g. Citizen of What C	Country?
	3a or		8808 Garfield Dr	ive		208	82		U.S.A.	•
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of	Hispanic Origin? (S can, Mexican, Puer	Specify Yes or No-	14. Race - Am Black, Wh	
9	after or Ite	Ī	1 Never Married 2 Married	1 ☐ Yes 2X No		1 ☐ Yes 27 No		10 1 10211, 510.)	Specify:	110, 010.
<u> </u>	ours Frail,	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				-	W	nite
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auč	ntal I	Be c	Adolph Hoehlin				T ₁ O1	uise Carr	ington	
2	should be nd Mental marked matic ev	ဥ	19a. Informant's Name/Relationship (19b. Mail	ing Address (Stree		ural Route Number, (Zip Code)
<u>≅</u>	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other traumatic as <u>once</u> .		Daniel S. Knowle		8808	Garfiel	d Drive.	Gaithersh	ourg. Mar	1and 20882
ā,	Hea Hea tem 3		20a. Method of Disposition	20b. Pla		osition (Name of ematory or other pla			oc. Location - City of	
ÖL	ages ant of it: If i		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Hemovai from State			- !	1/11/0/	1 1	. Wilmededa
Baltimore,	artme orten injur		21. Signature of Fundinal Service Licer	TIELI	2	tan Crem 2. Name and Addr	ess of Facility			a, Virginia
Ba	Ded die a		Novert L.	Villiams	1 2	6401 Rid	ge Road	P.A., Fu Damascus	Mary1ar	
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Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	□Ectopic pregnan	су		23d. Date of d Month	elivery Day Year
o	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	atn 5	Other (specify)				
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ds,	signe d be			Ÿ		, ,		1 🗀 Yes	2 □1√10 3 □ 1	Probably 4 [Unknown]
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3ec	has l	Completed						autopsy	ed? prior to	completion of cause of
a	n: Th iicate r. pag		25 10				00 Pl / P-	1 Yes 2		es 2 1 No
Vital Record	Physicien: The lav this certificate has al director, page 2	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☑	ERIOUTANTI	ent 3 DOA	thac	eath <i>(Check only one</i> Home 5 Resider		
of	Physical distribution	. To	27. Manner of Death		28b. Time	of 28c. In		28d. Describe hov		эвспу)
O	ding th. Afte fune	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		ork? □Yes 2□No			
Division	To the Hospitel or Attending Physiciem: within 24 hours after death. To the Funerel Director: After this certific: completely filled in by the funeral director.	ertification:	3 Suicide 6 Could not be determined		me, farm, s	treet, factory, office	9	28f. Location (Stre City or Town,		Rural Route Number,
Ļ	Hospitel or 24 hours afte Funerel Dir tely filled in I	C	29a. Certifier 1 Certifying Pl	nysicien: To the best of my know	wladne dos	th occurred at the	time, date and place	e, and due to the car	ISA(s) and manner	as stated
	24 hc Fun	edicai		miner: On the basis of examinat and manner stated.						
	To the within 2. To the complet	Me	29b. Signature and title of certifier	7		29c. Lice	nse number	29	d. Date signed (Mo	nth, Day, Year)
			> 8M 1//	11)		1	41728	(ma)	1/10/0	4
	10		30. Name and address of person who	completed cause of death (Item	23a) (Type	e, Print)	1/1/7"	1"	1///	1
		A STATE OF THE STA	Michael Coste			mans Lan	e, Frede	rick, Mar	yland 21	702
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signar		4	7 .			
	Regist	rar	IAN	A Show	AND	17	Ana. w 1			

DHMH 17 Rev 1/2001

Registrar

2004

Diamoia		1. Decedent's Name (First, Middle,	operFHG828 2/20/04 EW			2. [Date of Death	g. No. 5	Year	3. Time of	
Physic /Medi		Stella Kilpatrio	:k			Ja		10,	2004	9:56	A M
Exami		4a. Facility Name (If not institution,			own, or Location	of Death			unty of Death		
			re - Spa Creek Cen			24 Hrs of	Nato of Right		e Aruno		- Fomia
Funeral Director	_	174-01-7159	7. Age (In yrs. last to 1		Days Hours	Min. Ma	Date of Birth Month, Day, y 12,	1913	Penns	place (State o ntry) sy Ivani	ia
ehow	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location						10d. Inside Ci	•
a-f sh	ctor	Maryland Anne An	cundel Annapo	lis						1 X Yes	2 🗌 No
or 28	Oire	10e. Street and Number		10f. Zip (_	of What Cou		
ath w	rai	776 E Fairview A	12. Was Decedent Ever in U.S.	2140		inin? /Specify			d State		
Item Item	-une	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed Forces?		ent of Hispanic Ori fy Cuban, Mexican		n, etc.)		Black, White,	etc.	
ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Itam 27 is marked other then "natural", or Itema 23a or 28a-f ehow or other treumatic event, the Medical Examinar must be regilied at	Completed by Funeral Director	3 MWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:			Sp	ecify: Whi	Lte	
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should be Ind Mental I	To Be	Michael Tanchuk			Mary	Meskow					
2 should be fited within and Mental Hygiene. Is marked other then eumatic event, the Ms	-	19a. Informant's Name/Relationshi		9b. Mailing Address							
and 2 salth n 27 i		John W. Doxey /		76 E Fair		in .		•	ry land		
of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	LIRemoval from State	of Disposition (Nami tery, crematory or off	ŧ.,	Date			ion - City or T		
Pag Iment tant: jury o		`4 □Donation 5 □Other (Spe	ecity) Balti	more Crem		/13/200	04 B	altin	nore, 1	Marylar	ıd
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 ti any injury or other tre 20058.		21. Signature of Funeral Service Vi	lla_	147 Du	Address of Facili	Johi ouces t	er St.	Ant	r Funer napolis		140
Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, to immediate cause. Enter Underfying Cause (Disease or injury that initiated avents	a. Due to (or as a consequence) Due to (or as a consequence)	Osteop						Onset and (Death
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			For State Registrar	State	of Marylan	•	artment tificate			and Me	ental H	ygie: Reg.	201	14	02274
	Physicia	an	1. Decedent's Name (First, Mide							2	2. Date of E Month		Day	Year	3. Time of Death
	/Medic		Kenneth Ray I		·basl		4h Cih.	Four or	Location o	of Do ath	Jan.	11,	2004 4c. County of	of Death	3:30 AM
	Examin	er	4a. Facility Name (If not institution 328 S. Mont N						town	n Death			Wash		on
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2	24 Hrs. 8 Min.	B. Date of E (Month, L	Birth			place (State or Foreign
	Director		216-50-2818	1⊠M 2□F	56	Yrs.	Months	Days	Hours	M	arch	24,	1947		ryland
	pug *		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. Cit	y, Town or Lo	cation							1	10d. Inside City Limits
	Manyi	ō	Maryland Was	shington		Hage	ersto	wn.							1⊠Yes 2□No
	r 28a	irec	10e. Street and Number				10f. Zip				-	10g.	Citizen of W	hat Coul	ntry?
	15 with with 123 of 123	Funeral Director	328 S. Mont V	Valla Aven	ue				1740				USA		
	teme teme	uner	11. Marital Status	Armed F		.S. 13.	Was Deced f Yes, spec	ent of Hi ify Cuba	ispanic Orig n, Mexican	gin? (Speci ı, Puerto Ri	ify Yes or Nican, etc.)	10-		- Americ c, White,	can Indian, etc.
36	rseffe i', or i	byF	1 ☐ Never Married 2 ☒ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes G	2 🕅 No ive Dates:		1 ☐ Yes 2	2[X]No	Specify:				Specify:	w	hite
21215-0036	within 72 hours effer deeth with the Marylend ene. Than "neturer", or iteme 23e or 28e-f ahow he Medical Examiner must be notified at	ted	15. Decede	ent's Education		16a. Dece	dent's Usua	I Occupa	ation	t of working		16b	. Kind of Bu	siness/In	dustry
2	thin 7	Completed	Elementary/Secondary (0-12)	college	(1-4or 5+)	1	<i>ofer</i>	e retired)	t of working	,		oofin	~	
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=	d be t	To Be	Tyson Harold							el Al				•	
aryi	a 1 end 2 should f Heelth end Men Item 27 is marke other traumatic	۴	19a. Informant's Name/Relation		_	19b. Mailir	ng Address	(Street a	and Numbe	er or Rural i	Route Num	ber, Ci	ty or Town, S	State, Zip	Code)
	end 2 elth e n 27 is		Kathleen Kega	rise - wif					Va11a						21740
Baltimore,	jes 1 en of Hee if item 3 or other		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation	n 3 □Removal from	State	Place of Dispo cemetery, crer	natory`or o	ther place		Dat			. Location - (_	
ᆵ	nit. Pagea ortment of to ortant: if ite injury or of		`4 □Donation 5 □Other		Ros	se Hil		-	y s of Facility	1/15/		_	lagers FUNE		, Maryland
Bal	permit. 1 Depertm Importal eny inju		21. Signature of Funeral Service	T MY	ninus	16 17				-			wn, M		
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that	caused the deat								-		Approximate Interval Between
	- nysician		Immediate Cause (Final disease or condition	1	voner	u a	ter	01 (dice	and	2			- 1	Onset and Death
1	/Medical Examiner		resulting in death)		(or as a conseq)							
	LAGIIIII	ē	Sequentially list conditions,	b. Due to	(or as a conseq	lvide lu-nce of):	mlo							-	•
	uted d ansit	mln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its tool expense.	< −	(1)										
o`	te be executed ysicien end he buriel-trensit	Examin	that initiated events resulting in death) Last	Due to	(or as a conseq	uence of):									
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39 X	deeth certifics ie ettending ph ad for use es ti	Physician/Med	IF FEMALE:	23c. If yes, o	utcome of pregna	ancv							23d. Date	of delive	ao.
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s, D	The law requires thet the ste hes been signed by th pege 2 should be detache	þ	Part II. Other significant condi	tions contributing to	death but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did	ľ		bute to ti 3 ☐ Prot	he cause of death?
ord	v requir been s should	eted	Toperta	3015[0]	1 2 4 :	222		0			7	Yes		(10,2) -0.0	
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		မ င်	25. Was case referred to media	cal					26 Place	of Death (1 ☐ Yes		No 1	□Yes	2 No
Ē	yalci is car direc	Ho B	examiner? 1 ☐ Yes 2 No	Hospital	Inpatient 2	ER/Outpatier	nt 3□ DO	A Othe	0.0	rsing Home			6 □Othe	r (Specif	(y)
_	D D D D	1.	27. Manner of Death 1 X Natural 5 ☐ Pend	(140	of Injury nth, Day Year)	28b. Time of Injury		8c. Injury Work			d. Describe	e how i	njury occurre	ed	
Sio	Attending in death.	cati	2 ☐ Accident invest		e of Injury - At h	ome farm str	M reet factors		Yes 2 □ I		Rf Location	(Stree	t and Numbe	r or Bur	al Route Number,
Division	or Ai	Certification;	4 ☐ Homicide dete	mined 200. Flat	ding, etc. (Specif	fy)	eet, tactory	, onice			City or T				
	To the Hospitel or Attendin within 24 hours effer death. To the Funeral Director: At completely filled in by the fun			ying Physician: To the											
	the H	Medical	one)	and ma	nner stated.	TION AND OF IN					2 4((110 (1111				
	o ¥ o o	>	29b. Signature and title of certi	1201	MD		290	5-	9 number 7 <i>5</i> 7	7		1	Date signed	J.	cay, rodij
, ,	4		30. Name and address of person	on who completed car	use of death (Iter	п 23а) (Туре.	Print)	1)	1	<i>r</i> 1	/	11	1		
7	7		Fatimah	Ndinge	- , MD	24	Nh	all	hut	Stre	ef	Ha	gerst	own	1 MU C1790
6	Sta		31. Date filed (Month, Day, Yea	3 2004 A	Registrar's Signa	ature An	ulis								
	Regist	reir	- 1 1 1 2 1 m	- 2001	No section 1	. balo									

			riedse i	••	epartment of Health and N		_	
		•	1 - For State Registrar	•	Certificate of Death		1. No. 2004	02275
	Dharaini		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Edwin Marcel	l Kershner		Janua	in 11, 200	
8	Examin	400	4a. Facility Neme (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Deet	
			Washington County		Hagerstown day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washingt	
	Funeral Director		5. Social Security Number 215-14-1689 6. Security Number 10	7. Age (In yrs. last birtho	Months Days Hours Min.	June 20,	1923 Mary	hplace (State or Foreign untry) 7 Land
	pu ,		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town o	-1			10d. Inside City Limits
	Maryla f ahov	jo	10a. State 10b. County Maryland Washingt		cstown			1 Yes 2 No
	1 the	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Co	untry?
	h with	O le	901 Noland Drive	2	21740	U1	nited Stat	es
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No-	14. Race - Ame Black, White	
36	72 hours after death with the Maryland natural, or Items 23a or 28a-f ahow diest Evant er maat be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2□No 1943- If Yes, Give Year or Dates: 1945	1 ☐ Yes 2 ☐ No Specify:		Specify: Whi	lte
9	72 hours "natural", idical Exe		15. Decedent's Edu (Specify only highest grad		ecedent's Usual Occupation Give kind of work done during most of work lie. DO NOT use retired)	16	6b. Kind of Business/	
218	C 20	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				
21		Co	8	0 W6	elder/machinist		railroad	
ğ	e da la	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
2	ati ati	J.	Fred E. Kersh 19a. Informant's Name/Relationship (Ty		Blanche Mailing Address (Street and Number or Rur	S. Clari	Situat Town State	Zin Code) O.E. / 1.0
Maryland 21215-0036	d d d d d d d d d d d d d d d d d d d		Larry Schlotterbech		Jeanna Lane, Falli			
	Head Head the		20a. Method of Disposition	20b. Place of D	Disposition (Name of		Oc. Location - City or	
Baltimore,	00		1 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	lemoval from State Rest Ha	erematory or other place) aven Cemetery 1-14		agerstown,	Maryland
alti	그 된 본 분 .	16	21. Signature of Funeral Service Licens	99	22. Name and Address of Facility M11	mich Fune	eral Home	
œ.	Depa Impo any i		fred LiVest	al	415 E. Wilson Blvd.	, Hagerst	lown, Mary	land 21740
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not not cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition resulting in death)	1 neur	une, Del	ateral		1 cloud
	/Medical Examiner		1650Ming in Goziny	Due to (or as a consequence of)	7010	Class		710
	e Ass	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of)	over +			1 cleys
	uted d ansit	Examln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Therepry			
oʻ	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a consequence of)				
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89 x	death certificate I e attending physi id for use as the b	Med	IF FEMALE:	20-16				
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
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S, P	The faw requires that the tie has been signed by the bage 2 should be detache	by Pr	Part II. Other significant conditions co.	ntributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	cco usa contribute to	the cause of death?
rds	w requires been sign should be		Hudskins	isucère	(1 ☐ Yes	2 □ No 3 □ Pr	obably 4 @Unknown
of Vital Record	e law re has bee ge 2 sho	Completed	Ceronan A	orley 1 Str	216	24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
H		ĕ	A brief Fil	soullation.		performe	death?	2 No
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?			th (Check only one)		
)	× 5	은	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outp			ce 6 Other (Spec	cify)
	ding Ph h. After thi funeral	tlon	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury 28b. Tin (Month, Day Yeer) Inju		28d. Describe how	injury occurred	
Division	I or Attendii after death. Director: A I in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury At home, farm		28f. Location (Stre	et and Number or Ru	ral Route Number,
ā	rs after safter at Dire	Certification:	4 Homicide	building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, oner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2.	Mec	29b. Signature and title of certifier	/	29c. License number	290	d. Date signed (Month	n, Day, Year)
			Landon I	I Va I Ind	1221.22	T	enliser 11	2144
	1041		30. Name and address of person who co	ompleted cause of death (Item 23a) (Ty	ype, Print)	Λ .	7.1	1
5H	1041		Freiler II	MSS III WY III	10 medical Cons	ms tel	1-egeri	form mis
	Sta Registi		31. Date filed (Month) Car, Year)	32. Segistrar's Signature	Spell		3	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:30 p M Ruth Helen Lovell January 4, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 16, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1□M 2√F Yrs. Ĩ915 Maryland Director 215-07-4810 88 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Hampstead Director Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21074 4616 Lower Beckleysville Road USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No Il Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clothing Seamstress 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace V. Utz Preston W. Utz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4616 L. Beckleysville Rd, Hampstead, MD 21074 Joan A. Lovell, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 01/07/2004 4 ☐ Donation 5 ☐ Other (Specify) Finksburg, MD 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility M607 Eline Funeral Home DUC. 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bilatera **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident s after death the 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 🗌 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide within 24 hours at To the Funeral D completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 39102 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 Mayn S tosain 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Description Construct Name (First Models, Lat) Construct Name (First Models, Lat) Construct Name (First Na					State of r	viaryiani		tificate of		mentai Hyg	jiene leg. No. 2 (nnu	02279
CARROLL JAMES LITTLE Control Service of the Country Control Service of The Control Serv		Physic	ian	1. Decedent's Name (First, Middle, I	ast)					2. Date of Dea	th		. Time of Death
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Due to (or as e consequence of): Comparison of the part of the				disease or condition .	e	Landen .	3140	1011	42	021/ 1	Lorda	(ניים	14-
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DHMH 16 Rev 6/95

			1 - For State of Maryland / Dep. Registrar Ce	artment of Health and Mertificate of Death	ental Hygie	71111	02279
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		ELLEN LOUISA LUTZ			Day Year 11 200	4 12:00 a. M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	Exami		Edenton Nursing Home	Frederick		Freder	ick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		thplece (State or Foreign ountry)
Ro.	Director		219-36-4175 1□ M 2♥F 88 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 22,	915 Ma	ryland
	pu 🖢		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	easting			101 1-11 0: 11 ::
	anyla eho	2					10d. Inside City Limits 1 ☐ Yes 2(T)No
	28a-f	ectc	Maryland Frederick Frederic		1.2		
	with the Maryland a or 28a-f ehow be notified at	Funeral Director	10e. Street and Number 5911 Genesis Lane	10f. Zip Code 21703	10g.	Citizen of What C	ountry?
	eath	erai		Was Decedent of Hispanic Origin? (Spe	cifu Vac or No-	USA 14. Race - Am	erican Indian
	ter d	Ë	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, Whi	
21215-0036	hours after death with the Maryland tural; or Itams 23e or 28e-f ehow al Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: [Thite
9	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	ident's Usual Occupation	161	. Kind of Business	/Industry
21	within 72 ho ene. than "natu he Medical	nple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired)	ig		
2	filed wi Hygien other th	Co		ool Teacher		Public S	School
פ	d d b	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u> </u>	should I and Meni marke	ဥ	William Solomon Wachtel		en Howar		
Maryland	C1 00 = 00	0 0		ing Address (Street and Number or Rural			Zip Code)
	s 1 and of Health Item 27 other to	1 8		Old Stage Road, Fre			Taura State
Baltimore,	0 0			matory or other place)		. Location - City or	
	permit. Pages Department of Important: If It eny injury or o			Lutheran 01/1 2. Name and Address of Facility		ersville Lain Stre	, Maryland
g	Depa Impo eny i	li J		cicketts Funeral Ho			
-		A) A	July 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			ville, H	Approximate
			23a. Part1. Enter the disease of complications that caused the death. Do not enter shock, or hear failure. List only one cause on each line.				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)				3 weeks
	Examiner		Due to (or as a consequence of):	im			10 years
ğ.		e	Sequentially list conditions b. Due to (if as a consequence of):	1010		-	7003
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events c.				
ĵ	be executed icien and burial-transit		resulting in death) Last Due to (or as a consequence of):				
=	0 % 0	Icai	d				
9	as l	Physician/Med	IF FEMALE:				
X R R	death ce e attendi ad for use	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of de Month	
	the a	sic	1 Yes 2 No 9 Unknown 9 Unknown 5	Other (specify)		Month	Day Year
ŗ.	w requires that the death cer been signed by the attendir should be detached for use		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I	23e Did tobacc	o use contribute to	the cause of death?
ds,	signe d be	d by	Dementia	moonying occase given are area.	1 ☐ Yes	N/	obably 4 Unknown
ecord	y requ	ompieted			-		
ě	e la has je 2	m			24a. Was an autopsy performed	prior to	itopsy findings available completion of cause of
		O	25 W		1 Yes 2 X		2□ No
VITAI		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	26. Place of Death			
ō	Phys or this oral di	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of	f 28c. injury at 2	e 5 🗌 Residence		cify)
0	nding P Ith. : After t e funera	ig	t Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,,	
DIVISION	Attender death ector:	ertification;	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, str	reet, factory, office 2	Bf. Location (Street		ural Route Number,
5	el or s afte el Dir	Cert	4 Homicide building, etc. (Specify)		City or Town, Si	ate)	
	ospii hour unere ly fille		29a. Certifier (Check only (Ch	h occurred at the time, date and place, an	nd due to the cause	(s) and manner as	stated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ledical	one) and manner stated.				
	To To	Σ	29b. Signature and title of certifier	29c. License number	1	Date signed (Mont	
			> dee MD	D42641	1	-12-	2004
			30. Name and address of person who completed cause of death (Item 23a) (Type,	D42641 Court, Frederic,	L M1	v. Par 1	01700
	Sta		31. Date filed (Month, Day, Year) 32. Registrants Signature	cours, Freamon	Ciria.	yearner	41100
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <u>06</u> 02:45 PM Rosemarie Hildegard Whilhemia Gertrude Linenberger 2004 Jan. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 185 Sunbrook Lane Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/05/1924 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 152-12-3640 Director 79 Germany Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 17 Is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Hagerstown Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 USA 185 Sunbrook Lane within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ğ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "n any injury or other traumatic event. In anseem Elementary/Secondary (0-12) College (1-4or 5+) Business Services 12 Management Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gertrude Johanna Steinborn Hermann Ernst Lulwes ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Crossgate Drive, Crofton, MD 21114 Deborah L. Werre / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 01/09/2004 Hagerstown, MD 21. Signature of Funeral Service Licensi 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** ONGESTIVE HEARI TAILURE 2-3 YEARS /Medical resulting in death) Due to (or as a consequence of) Examiner ANDIO MY OPPITH YEMS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed DRONARY ARTERY YEAR that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. F ed by the a 1 ☐ Yes 2 ☐ No 9 Unknows 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ should be 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe certificate of Vital 1□ Yes 3⁄2 No ector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27 Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 137892 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 11110 Medical Campus Rd., Ste. 130, Hagerstown, MD 21742 Dr. Pamela Bradford 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	larylan		artmen rtificat				R	eg. No.	200	022	81
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	and *		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City	Limits
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	Funeral		5. Social Security Number 6. Sex	M 20XF 7.7	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Dey, Apr. 2,	Yeer)	9. Birth	nplace (State untry)	or Foreign
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Division of Vital Records,	or Attending Physician: after death. Director: After this certifica in by the funeral director. F	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		Injury - At ho , etc. (Specify						28f. Location (Si City or Town		umber or Ru	ıral Route Nui	mber,
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	WSL		30. Name and address of person who co	mpleted cause	of death (Item	23а) (Туре,	Print)	<i>ک</i>	John	120 N	1 DR	re	EDER	ick, mi	2 1762
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			1 - For State Registrar	State of	Maryland / D		ment of Ho				giene Reg. No.	004	022	283
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	Funeral Director		213-34-6860	1 □ M 2 🖾 F			lonths Days	Hours	Min.	8. Date of Birth (Month, Day April	, Year) 3 1930	Cour	ntry)	
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F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Cer	ebro	Ma	SAU	las	((acci	der	STIL	101	245
ļ,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or Due to (or d.	as a consequence of	or): or):	++	H	Pe	ater	754	on	400	45
.O. DOX 00	ine law requires inat the uearn certilicate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2 Fetal death		opic pregnancy her (specify)					Date of delive	ry Day Ye	ar .
(2)	uires ina signed l	Ď	Part II. Other significant condition	ns contributin to deat	th but not resulting in	the under	rlying cause giver	n in Part I.		23e. Did to	1		e cause of dea ably 4 □Un	
5	s beer	ojete	RIAHT R	etrum	white	195	M	100	32	24a. Was a		b. Were autor	osy findings av	variable
ָבְּיוֹ בְּיוֹיִים בייויים	rsicien: The law s certificate has t director, page 2 s	Completed	1 110/11		1 32 1 1 1					autops perfor	sy mgel? 2% No	death?	npletion of cau 2000	use of
	entific ector,	Be	25. Was case referred to medical examiner?	Vassitali > A	- 2-090 xxx				of Death	(Check only or	16)	- /		
5	This of this all directions	မ	1 Yes 2 No	-	atient 2 ER/Out		3□ DOA Other	4 LI NU		ne 5 Reside			")	
	After this funeral di	ion:	27. Manner of Death 1 Natural 5 Pending	,		ijury	28c. Injury Work	?		28d. Describe h	ow injury occ	curred		
מו	death death stor: ,	icat	2 Accident investig 3 Suicide 6 Could n	ot be 29a Place of	I laium. At home for			es 2 🗆 h		196 Landing (C	A			
	or A after o	Certification:	4 Homicide determine	ned 286. Place of building	Injury - At home, far , etc. (Specify)	m, street,	factory, office		2	28f. Location (Si City or Town		mber or Rura	i Houte Numbe	3 <i>r</i> ,
- !	To the hospital of Attanding Prysticien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical Ce	(Check only 2 Medical I	g Physician: To the be xaminer: On the basi	est of my knowledge, is of examination and	death occ	curred at the time	e, date and	d place, a	and due to the c	ause(s) and	manner as st	ated.	
	the f the f	Medi		and manner	r stated.									
1			29b. Signature and title of certifier	. (29c. License	riuinoer	A.T.	_ 2	.eu. Date sig	ned (Month, I	Jay, Year)	
1	Ev		HR1802		ayob)	111-1	DD.	20	، در	2	1/3	0 10	4	
Ĺ	5000		30. Name and a draw of person	who is implified a fuse of	of th (Item 23a) (Type, Prin	1 5UM	とし	05	200	000	11199	WILL	3
	() ///	to	31. Date filed (Month, Day, Year)	32. Reg	Strar's Signature	OC	2055	1047	105	DK.	Wi) 2	417	
	Sta Registr		IAN O	5 2004	Goras D.	de	rester							

			For State Registrar	State of I	Maryland		artmen rtificat					giene Reg. No. 2	004	02	284
			1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea	ath Day	Vana	3. Time o	f Death
	Physici /Medio		Penny Lynn Mer	riman McLar	ne						January		Year 2004	4:00) A M
	Examir		4a. Facility Name (If not institution	n, give street and numb	er)		4b. City,	Town, or	Location of	of Death		4c. Coi	unty of Death		
			17 Peach Orcha	rd Court			Bru	nswi	ck			Fr	ederic	k	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs. last		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	/. Year)	Cour	olace (State	
	Director		215-64-1615	1 M 2 L3.F	49	Yrs.	l, . l				Nov 15,	1954	Brun	swick,	, MD
	and *		Usual Residence of Decedent 10a. State 10b. Count	,	10c. City, T	own or Lo	cation						1	0d. Inside C	City Limits
	f sho	5	MD Frede	rick	Bru	ınswi	ck								2 No
	28a-	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cour	ntry?	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than *natural; or Itams 23e or 28e-f show event. I've Medical Examinar must be notified at	<u></u>	17 Peach Orcha	rd Court			2	1716				U	SA	•	
	ms 2	Funerai	11. Marital Status	12. Was Decede		13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Americ		
9	after or Ita	Ē	1 Never Married 2 Ma	Armed Force			ir ves, spec 1 ☐ Yes		n, Mexicar Specify:		Rican, etc.)	1	Black, White,		
8	ours	d by	3 ☐ Widowed 4 ☒ Divorce	If Yes, Give Year or Date	es:		10 162	ZLALINO	зресну.			Spe	ec <i>ify:</i> Wi	iite	
21215-0036	72 h	Completed		nt's Education est grade completed)	1	6a. Dece (Give	dent's Usua kind of wo DO NOT us	l Occupa rk done d	ation <i>Juring m</i> os	t of work	ing	16b. Kind o	of Business/In	dustry	
121	han han	ш	Elementary/Secondary (0-12)	College (1-4	or 5+))			**			
2	filed within Hygiene. Ither than ent. I've Me		17. Father's Name (First, Middle	/ ast)		Hou	sewif	e	18 Mothe	r's Nam	e (First, Middle,		maker		
Maryland	12 should be filed within n and Mental Hygiene. 7 Is marked other than "traumatic event, tha Me.	Be	Donald Robert	·							ou Green		name)		
2	shoute of Me mark matic	၉	19a. Informant's Name/Relation			19b. Mailir	na Address	(Street a			al Route Numbe		wa State Zia	Code)	<u> </u>
<u>S</u>	d 2 s lih an 27 ls trau	0 03	Betty Merriman								unswick			0000)	
ō,	is 1 and 2 should of Health and Men itam 27 is marke other traumatic	133	20a. Method of Disposition	, Hounes	20b. Plac	e of Dispo	sition (Nan	ne of	- 1		Date		on - City or To	wn, State	
2	00		1 ☑ Burial 2 ☐ Cremation 1 ☑ Dopation 5 ☐ Other (natory or o			1/16	/2004	Bruns	wick, N	ďD	
Baltimore,	permit. Page Department Important: If any injury or once.		21. Sign yun Funeral Service		11.		2. Name an				The state of the s				
ñ	Eg m s g		barbara A.	Williams,	wilean	e.	John '	r. W	illia svill	ms I	uneral ad, Bru	Home	z MD '	21716	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that cau	sed the death. [اللا و	Approximation and the second s	te
	Physician		Immediate Cause (Final	1 only one cause on each	there	7 -								Onset and	Death
	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequen	nce of):						ro salan		10 y	lairs
н	Examiner		Conventially lies and delana	b Ch	conic	06	stru	ctin	2 PU	lmo.	nany.	Dis	ease	74	ears
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequen	ice of):	7.				sease			/	
	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examin	that initiated events resulting in death) Last	c	tersi	efec	2(_	10	ng	di	SCISC			ye	avs
60,	cian a		rooding in county East	Due to (or	as a consequen	ice or):		-	J						
8760,	physi	dice		d									-		
9 ×	ding se as	Me	IF FEMALE:	23c. If yes, outcome	me of pregnancy	,						924	Data of delice		
Вох	eath certific attending p for use as	ian	23b. Was decedent pregnant in the past 12 menths?	1 Live birth	1 2 ☐ Fetal de t at time of death	ath 3[Ectopic pr						Date of delive Month	<u>-</u>	Year
o.	tt Ihe de by the tached	Physician/Medical	1 Yes 2 No 9 Unknown	9□ Unknow		. 3	_ Ourer (3p	BUILTY							
Δ.	res that igned b		Part II. Other significant condit	ions contributing to deat	h but not resultin	ng in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use c	ontribute to th	e cause of o	death?
rds	n sign	d by	Diabe	tes M	elli	4is					ĭ×(Y	es 2□N	o 3 ☐ Prob	ably 4 □	Unknown
S	law requas been 2 shoult	iete									24a. Was a	n 24	b. Were auto	psy findings	available
of Vital Records,	The la	Completed									autop:	med?	prior to con death? 1 \(\sum \text{Yes}	npletion of c	ause of
tal		0	25. Was case referred to medica	af				-	26. Place	of Deat	1 Tes	22 No	1 195	20110	
<u>></u>	S	To B	examiner? 1 ☐ Yes 2 No	Hospital:	atient 2□ER	/Outpatier	ıt 3□ DC	A Othe	M**	rsing Ho	~		Other (Specify	<i>(</i>)	100
			27. Manner of eath 1 Natural 5 ☐ Pendi	28a. Date of I	njury 28 Day Year)	b. Time of	2	8c. Injury Work	at	- 31	28d. Describe h	ow injury oc	curred		
Θ̈́		atic	2 Accident invest	igation			М	1 🗆 \	′es 2 🗆 i	No .					
Division	l or Attan after deatl Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	nined 289. Place of	Injury - At home etc. (Specify)	, farm, str	eet, factory	, office			28f. Location (S City or Tow	treet and Nu n, State)	ımber or Rura	l Route Num	iber, 🕌
	ospital or A hours after uneral Directly filled in by									1					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only 2 Medical one)	ng Physician: To the be Examiner: On the basi	s of examination	dge, deatl and/or in	n occurred vestigation,	at the tim in my op	e, date an inion, dea	d place, th occuri	and due to the c ed at the time, d	ause(s) and late and plac	manner as st ce, and due to	ated. the cause(s	s)
	thin 2 the mple	Med	29b. Signature and title of certific	and manner	stated.		290	. License	number		2	9d. Date sid	ned (Month,	Day Year)	
	E ₹ 5		100.	Tala	. 0	MAIT				37		_			
	b		30. Name and address of person	who completed source	of death (train an	a) (Tues	ر ا	دب	5666			1 1	7-0	7	
	V		So. Name and address of parson	Shrem A	AD	/ (Type,	(1)	oct	50,	1021	the St	Fr	forist.	LUT	2171
	Sta	te	31. Date filed (Month, Day, Year	J - V	istrar's Signature	,	1	-31	100	4	(1 164	ME ICI	70 10	alul
	Registr	_	JA	V 1 4 2004▶	Senar		29	de	ouk.	2/					

			1- State Registrar amended#lpe					nd Mental Hyg	giene 2 (004	02285
	Physici /Medic		1. Decedent's Name (First, Middle, Last) M	ackay łackay				2. Date of Dea Month January	Day	Year	3. Time of Death 1:15 A M
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of			y of Death	1.13 A
n			Homewood At Cruml	Land Farms		Fred	erick			Frede	rick
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days		Min. 8. Date of Birth (Month, Day May 21,	Year)	9. Birthp	olace (State or Foreign
Section	Director		Usual Residence of Decedent	M 2XJF 89	Yrs.			May 21,	1914	New	Jersey
	land W		10a, State 10b. County	10	C. City, Town or Lo	cation				1	Od. Inside City Limits
	Mary -1 ah	Į.	Maryland Frederic	k F	rederick						1X Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			l0g. Citizen of	What Cour	ntry?
	h with	al D	7407 Willow Drive			21702			U.S.A		
	Items :	Funeral	11. Marital Status 1 1 □ Never Married 2 🖾 Married	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 2 No		Was Decedent of Hi f Yes, specify Cuba	spanic Origir n, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)		ce - Americ ick, White,	
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. is marked other than "natural", or items 23s or 28s-1 show eumatic event, the Madical Exumenermust be notified as	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Speci	fy: W	hite
7	"natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa	lurina most o	f working	16b. Kind of B	lusiness/Ind	dustry
12	withir ene. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	Artist	DO NOT use retired,)		Art		
0 0	filed within Hygiene. other than		17. Father's Name (First, Middle, Last)	4	ALLIST	-	18. Mother's	Name (First, Middle,		me)	
ylan	should be ind Mental marked c	To Be	Robert Da Costa				Edna				
Mar	ges 1 and 2 should n of Health and Men i if item 27 is marke or other treumatic		19a. Informant's Name/Relationship (Typ. Neil Mackay - son	oe, Print)				or Rural Route Number ne, Freder:			
ā,	1 and Health Iem 27 other tr		20a. Method of Disposition	[2	20b. Place of Dispo	sition (Name of			20c. Location		
ē E	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☑Cremation 3 ☐Re 4 ☐Donation 5 ☐ Other (Specify)		cemetery, cren	natory or other place Cremato	ry 1/		rederic	-	
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service License	· po	100	. Name and Addres		Stauffer	Funera	1 Hom	es, P. A.
	40340		Sharow Canull	e Ollue				Pike, Fred	lerick,	Mary	1and 21702
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Alzh.	er the mode or dying	\	Ym enti			Approximate Interval Between Onset and Death
34 34	/Medical Examiner			Due to (or as a co	nsequence of):		>				
	ed sit	iner	5 aquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ensequence of):						
<u> </u>	be executed sician and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a co	insequence of):					-	
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٥	ng ph as th	Med	IF FEMALE:								
Box	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of p 1 Live birth 2 4 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)				te of delive onth	ry Day Year
Ö.	at the de by the	hysi	1 ∐ Yes → No 9 □ Unknown	9□ Unknown	0.000	- Ciridi (Speciny)					
Records, F	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions cont	inbuting to death but no	ot resulting in the ur	iderlying cause give	n in Part I.		oacco use cont os2_No		e cause of death? ably 4 Unknown
ဝင္ပ	law re as bee 2 sho	Completed						24a. Was a			psy findings available
	The ate h page	Con						perform	ned?	death?	npletion of cause of 2 No
Vital	sician: Th certiticate rector, pag	Be	25. Was case referred to medical examiner?					Death (Check only on	9)		
0	Physician: this certitic ral director.	2	1 163 3 100		2 ER/Outpatien		4 Jursii	ng Home 5 ☐ Reside)
	ing Atter une	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injury Work	?	28d. Describe ho	w injury occur	red	
UIVISION	Atten deat ctor: y the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre		es 2 □No	28f. Location (St. City or Town	reet and Numb	er or Rural	Route Number,
2	To the Hospitel or within 24 hours after To the Funerel Director completely tilled in b	0	29a. Certifier Certifying Physi	cian: To the best of m		accurred at the time	o data and a		,		, , , , , , , , , , , , , , , , , , ,
	the Hos hin 24 h the Fun npletely	edical	(Check only 2 Medical Examina	er: On the basis of exa and magner stated.	mination and/or inv	estigation, in my opi	inion, death o	occurred at the time, da	ite and place,	and due to	the cause(s)
	To the To the comp	×	29b. Signature and title of certifier	6/1-		29c. License	number	29	d. Date signe	d (Month, E	Day, Year)
	à		Magn ((May 14	MY	MDD1642	28		1191	04	
	•		30. Name and address of person who con					1 10 7	1 01 ==	1	
			Casper E. Cline, II 31. Date filed (Month, Day, Year)	32. Registra/s		orreet, F	rederi	ck, Marylan	nd 2170	1	
3	Sta Registra		JAN 1 5	2004 \ 34	person	9 10	2. 1				

DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar	State of Marylar		rtment of Health tificate of Deat			ene g. No. 200	4 022	287
	Physicia		1. Decedent's Name (First, Middle, Last)			II CD A IIM		Date of Death Month	Day Year	3. Time of D	
	/Medic	al -	MA 4a. Facility Name (If not institution, give s		LLEN N	USBAUM 4b. City, Town, or Location		JAN. 4	2004 4c. County of Dea	9:26 I	P
	Examin	er i	LONG VIEW NURSI			MANCHEST			CARROLI		
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.			der 24 Hrs. 8.	Date of Birth (Month, Day,	9. Bi	rthplace (State or I	Foreign
	Director		212-01-0000	M 2XIF 92	Yrs.					RYLAND	
	and and	-	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City	Limits
	Mary a-f sh	ţō	MD CARROLL	W	ESTMI	NSTER				1 (XYes 2	2□No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?	
	s 23a	rai	23 TIMBER RIDGI		12 12 1	21157	Origin? (Specifi	Voc or No-	USA 14. Race - Am	erican Indian	
39	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "netural", or litems 23a or 28a-f show aumatic event, it a Modical Examination ust by multiple at	by Funerai	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:	- 1	Vas Decedent of Hispanic i Yes, specify Cuban, Mexi		an, etc.)	Black, Wh		
15-003	72 hou		15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occupation kind of work done during n	nost of working	1	6b. Kind of Busines:	s/Industry	
21	rithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	SEAMSTRES			SEWING F	ΔCTORV	
2	filed w Hygier other the		17. Father's Name (First, Middle, Last)		1				aiden Sumame)	ACTORI	
⊆	id be i ental I ked o ic eve	To Be		Y E. NUSBAU	Μ		CLARA	GERTRU	JDE HARM	AN	
ary	s 1 and 2 should I Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty	ре, Print)	19b. Mailin	g Address (Street and Num	mber or Rural R	loute Number,	City or Town, State,	Zip Code) 173	340
	P 5 5 5		LaRUE NUSBAUM -		- Control of the Cont		Y				7 •
ltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other 20058.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cren	sition (Name of natory or other place) TER CEM.	1 /8 / 0	440	0c. Location - City o ESTMINST		
altin	nit. Paratme content injury	1	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		22	. Name and Address of Fa	acility FLET	CHER 1	FUNERAL	HOME	
ä	permit. Departimporte Importe any inj		& Long 1/2	skynd		54 E. MAIN				MD. 211	57
	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or content shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the dealer cause on each line. Due to (or as a consection). Due to (or as a consection).	quence of):	er the mode of dying, such	as cardiac or re	espiratory arre	st,	Approximate Interval Between Onset and De 25 4	een
68760,	rificate be executed og physicien and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consec						16	
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Dec	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)	-		23d. Date of de Month		ear
s, D	w requires that I been signed by should be deta	d by Ph	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause given in Pa	art I.	23e. Did toba	acco use contribute s 2 No 3 F	to the cause of dea Probably 4 □Un	
of Vital Record		Completed						24a. Was an autopsy perform	ed? prior to death?	autopsy findings av completion of cau s 2 \(\square\) No	vailable use of
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	lospital:		Other	lace of Death (C				
	ing Phys After this uneral dir	lion: To	1 Yes 2 (1) No 27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	1 3 DOA 4	280		nce 6 ⊡Other <i>(Sp</i> w injury occurred	ecify)	
Division	al or Attending after death. I Director: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory, office	28f	Location (Str. City or Town,	eet and Number or F State)	Rural Route Numbe	er,
	To the Hospital within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	n occurred at the time, date vestigation, in my opinion,	e and place, and death occurred	d due to the ca at the time, da	use(s) and manner a te and place, and du	as stated. ne to the cause(s)	
	ro the within of the comple	Mec	29b. Signatur and title of certifier	and market states.	4	29c. License numb	per	29	d. Date signed (Mor	nth, Day, Year)	
	WIL		+ Choha W.	mille	In h	D25443		124	JAN. 5,	2004	
	3	1 5	30. Name and ddress of person who co				TMINST	ER, MI	21157		
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 8 2	32. Registrar's Sign		Angell .					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JANUARY 2004 **Physician** 5:45 PM JOHN EMMITT NORCUTT /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner CARROLL LORIEN ASSISTED LIVING COMMUNITY MT. AIRY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) PENNSYLVANIA 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F Funeral Deys Months Hours 80 Director 179-16-9672 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Funeral Director MT. AIRY MARYLAND HOWARD 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code UNITED STATES 17315 PINK DOGWOOD COURT 21771 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2(C) No Specify: Specify: WHITE ۾ 3 ☐ Widowed 4 ☐ Divorced WWII Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF CONSTRUCTION TELECOMMUNICATIONS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNE ELIZABETH STILES GEORGE WARREN NORCUTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) GLORIA NORCUTT / WIFE 17315 PINK DOGWOOD CT.; MT. AIRY, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State JAN. 8, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State FREDERICK, MARYLAND RESTHAVEN CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licenses RESTHAVEN FUNERAL SERVICES, SKKOT CODY P.A. 9501 CATOCTIN MTN. HWY. FREDERICK, MD 21701 confications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, yone cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) RESPIRATORS /Medical Examiner Physician/Medical Examiner certificate has been signed by the ettending physician and irector, page 2 should be deteched for use as the bunal-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 108 2 □ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1L Yes 211 No 1 ☐ Yes 2 ☐ NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medical Certification: To 1 Tes 2 No 4 Uniursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 2 Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State Registrar

32. Registrer's Signature

21)

31. Date filed (Month, Day, Year) 2 2004 JAN

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

JULIO J. MENOCAL, M.D.

1564 OPPOSUMTOWN PIKE; FREDERICK, MD 21702

D-31912

		Registrar			Ce	rtificate of	Death	7		Reg. No.		
Physici	an	Decedent's Name (First, Middle, I		0.5					2. Date of D Month	Day	Year	3. Time of Death
/Medic		Willia		01t					Janua		,2004	
Examin	er	 Facility Name (If not institution, g 	ive street and nu	ımber)		4b. City, Town, o		of Death		4c. (County of Dea	
		Frederick Memor	ial Hos	oital		Frede					Frede	rick
Funeral		5. Social Security Number 6	Sex 1₩ 2□F	7. Age (In yrs.	-	If Under 1 Year Months Days	Hours	r 24 Hrs. Min.	8. Date of B (Month, D	irth Day Year)	9. Bi	rthplece (State or Foreign Country)
Director		051-05-2155	X W ZUF		36 Yrs.				1130	Day Year)	G	ermany
>		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	ncation						10d. Inside City Limits
or 28a-f show	<u>_</u>			100. 0.								1 ☐ Yes 2 🛣 No
Ba-1	cto		derick		Frede					1		
or 2	Oire	10e. Street and Number				10f. Zip Code					en of What C	
Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itams 23s or 28s-1 show other traumatic event, the Medical Examinat must be rediffed at	by Funeral Director	990 Waterford					1702				ited S	
lams L	Ine	11. Marital Status	12. Was Dec	edent Ever in U orces? 2 No	.S. 13.	Was Decedent of H	lispanic Or an, Mexica	rigin? (Spe ın, Puerto l	cify Yes or N Rican, etc.)	10-	4. Race - Am Black, Wh	erican Indian, ite, etc.
2 5	Y.	1 Never Married 2 Married	I 1.1∑Yes If Yes, Gi	2 □ No ive Dates:1947		1□Yes 2K No	Specify	<i>':</i>			Specify: W	hite
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dice.	Completed	15. Decedent's (Specify only highest)	Education grade completed)	1	(Give	dent's Usual Occup kind of work done	durina mo:	st of workii	ng	16b. Kin	nd of Busines	s/industry
79. V	ig I	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	a)					-
Hygiene. other than ent, the M	Ö	12			Su	pervisor						Systems
nd Mental Hygiene. marked other than imatic event, the M	Be	17. Father's Name (First, Middle, La	st)						(First, Middl	e, Maiden S	Sumame)	
Mental arked o	ဂ္	George Olt					Ann	a Kut	chler			
and Is mu		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Numb	er or Rura	I Route Numi	ber, City or	Town, State,	Zip Code)
Health a		Nancy Pfeil / D	aughter			Old Free	deric			nont,	MO 217	788
nent of Hea int: If item iry or other		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3		1 .	Place of Dispo cemetery, crea	sition (Name of matory or other place	ce)	D	ate	20c. Loc	cation - City o	r Town, State
nt: M ry or		1 ☐ Burial 2 ☐ Cremation 3		Fr	ederic	k Cremate	ory	1-10-	-04	Fre	edericl	k, Maryland
Department of the Important: If its any injury or of once.		21. Signature of Funeral Service Lice	ensee	4.5	2:	2. Name and Addre	ss of Facil	ity Sta	uffer	Funer	cal Hor	ne
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/sician ledical aminer	er	23 Part1. Enter the disease, or consock, or heart fails. List or immediate Cause (Final diseasest condition resulting in death) Sequentially list conditions, if any leading to immediate	a. PN Due to Chr	(or as a consec	MIA Juence of):	or the mode of dyir						Approximate Interval Between Onset and Death
ng physicien and as the burial-transit	Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	quence of):							
igned by the attending be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live	utcome of pregna birth 2 Feta nant at time of conown	I death 3	Ectopic pregnancy Other (specify)	у			2	3d. Date of de Month	elivery Day Year
hed t	y P	Part II. Other significant condition	s contributing to o	death but not res	ulting in the u	nderlying cause giv	en in Part	1.	23e. Did	tobacco us	se contribute	to the cause of death?
sign Id be	d b	1+171							150	ĮYes 2□]No 3□F	Probably 4 DUnknown
been si should	lete	Pyslude win							24a. Wa	5 20	24h Were a	utopsy findings available
2 2	E G	1042 COLLAG COURT		· · · · · · · · · · · · · · · · · · ·					auto	opsy formed?	prior to	completion of cause of
cate.									1 ☐ Yes			s 2 No
is certificate ha	Be	25. Was case referred to medical examiner?	Henrital			011		e of Death	(Check only	one)		
this call dire	2	1 ☐ Yes 3 No	-		ER/Outpaties		4 🗆 14				☐Other (Sp.	ecify)
After funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion	of Injury oth, Day Year)	28b. Time o Injury	Wor	yat rk? Yes 2 □]No	28d. Describe			
s after d at Direct ad in by	Certifi	3 Suicide 6 Could no 4 Homicide determin	ad 288. Plac	e of Injury - At h ding, etc. (Special	ome, farm, st	eet, factory, office				(Street and own, State)		Rural Route Number,
within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) Certifying 2 Medical Ex	aminer: On the b	e best of my kno casis of examina nner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date a ppinion, de	nd place, a ath occurre	and due to the ed at the time	e cause(s) a e, date and	and manner a place, and du	is stated. e to the cause(s)
To the	Σ	29b. Signature and title of certifier	An			29c. Licens	e number			29d. Date	signed (Mor	th, Day, Year)
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- > - 0		30. Name and address of person w	no completed cau	ise of death (Iter	n 23a) (Type,	Print)	4 (g C	1		1	0 1	

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) $^{\text{Day}}10,2^{\text{Year}}04$ **Physician** PRINTZ January 5:35 AM LEON WILLIAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 15, 1926 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X**] M 2□ F 77 233-34-3748 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "naturel", or Items 23a or 28e-f show the Medical Examinat must be ricitified at 1 XYes 2 No Thurmont Director Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 14 Ore Mill Place 21788 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1000 Ses 2 □ No If Yes, Give Year or Dates:1 944-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 XMarried 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired round 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry park & planning Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. am 27 is marked other than supervisorcommission maintenance 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kirby Printz Elizabeth Dodson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 Is any injury or other trau Delores Printz/ wife 14 Ore Mill Place Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Locetion - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 1/13/2004 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Figneral Service Lice 11802 Liberty Rd. Libertytown, MD 21762 Marine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetat dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed þ 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 3□ DOA Certification; To 2 ER/Outpatient this s after death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Deat Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CIM NI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 Silarex Ct. LeeMD Stephen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JAN 13

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar item#17,01-21-04,TCHD,srr Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 0658 M Pickrum Mae Januar 10 2004 mma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chestertou If Under 1 Year | If Under 24 Hrs. (ent Chester Center Hospital 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 ☐ M 2 😿 F 92 Ohio 298-16**-**2427 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Kent Chestertown 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a 10590 Cliff 21620 **USA** Road death Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ₩ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Y.M.C.A., Wilmington, De. 12 Cook .. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If item 27 is marked other tigury or other traumatic event, IL. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 01ivia HillBlayless Harvey Bayless 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Pickrum / Son 10590 Cliff Road, Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 PBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 01/17/2004 Chestertown, maryland Cemetery Janes 22. Name and Address of Facility Bennie Smith Funeral Home Road 298, Chestertown, Maryland 21620 Dhi Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to for as a consequence **Examiner** 4 week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury for as a consequence of Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last physician ar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the the attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ŏ Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate Reners 1 Yes nonsustained 2 740 Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Dimpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺No ٩ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Certification: 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation hours after death uneral Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Funeral 1.7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 1 within 2 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar liesterlown

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		i lease i	State of Maryland				1	iene o o o i	
	•	1 - For State Registrar		•	tificate of			leg. No.	02292
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
Physic /Medi		Evelyn Lucil					January		5:15P. ^M
Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, o		Death	4c. County of Dea	
Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. las	st birthday)	Freder	If Under 24	Hrs. 8. Date of Birth Min. (Month, Day		thplace (State or Foreign ountry)
Director		470-10-0867	M 2√5√F 88	Yrs.	Months Days	Hours	July 12		nesota
and w		Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Lo	cation				10d. Inside City Limits
Maryl -f sho	ţ	Maryland Frederic	ck Fre	ederio	ek.				1 ☑ Yes 2 ☐ No
DEBILITHOICE, IMELY JEING Z.I.Z.I.3-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, to Mexical Exeminar must be notified at any injury or other traumatic.	Funeral Directo	10e. Street and Number 5955 Quinn Orchard	Road #219		10f. Zip Code 2170)4		10g. Citizen of What C	ountry?
death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. \	Vas Decedent of F	Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Whi	
s after	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		I □ Yes 2 1 No				hite
-UCSO	ed b	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occup	pation		16b. Kind of Business	/Industry
Pin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done DO NOT use retire	during most o d)	or working	Doliator	
ted will lygien her th	Con	17. Father's Name (First, Middle, Last)	4	MILS	ssionary	18 Mother's	s Name (First, Middle,	Religion	
Viano ould be file Mental Hy arked oth	To Be	Oliver R. Speed				Li	llian May	Miller	
Mar nd 2 sho lith and 27 is m	1 8	19a. Informant's Name/Relationship (Ty Richard W. Palmer/I					or Rumal Route Numbe ld. #219 Fr		
of Hear	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Pla	ce of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location - City or	Town, State
Saltimos Sermit. Pages Department of important: If it in injury or once.		*4 ☐ Donation 5 ☐ Other (Specify)	Mt.				17/2004		
Dan permit Depart Impor		21. Signature of Pyneral Service Licens	30				Stauffer F Pike, Fre		TO DESCRIPTION OF THE PROPERTY.
M.		23a. Part L Ent r the disease, of compleshock, learn failure. List only or	ications that caused the death.						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Cetheros	clero	Ac Co	ulio	vascular	desus	On and on all Denth
/Medical		resulting in death)	Due to (or as a conseque	ence of):					1
xumile,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
cuted nd ransit	Examiner	that initiated events	c						
observated in the physician and by the burial-transit	EX	resulting in death) Last	Due to (or as a conseque	ence of):					
BOX 68 / leath certificate to attending physical for use as the b	dicai		1						
OX C	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan- 1 Live birth 2 Fetal of		Ectopic pregnanc			23d. Date of de	
o death	by Physician/Med	in the past 12 months?	4 Pregnant at time of dea		Other (specify)			Month	Day Year
hat the detache	Phy	9 Unknown Part II. Other significant conditions co	ntributing to death but not resul	ting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute I	to the cause of death?
Hecords, P.O. Box by The law requires that the death certifica the has been signed by the attending ph page 2 should be detached for use as th							1 🗆 Y	′es 2 No 3 P	robably 4 Unknown
tw req	ojete						24a. Was	an 24b. Were a	autopsy findings available completion of cause of
The lav	Completed							rmed? death?	
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on Control of the con	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	nrk?]Yes 2.∐No		•	
DIVISION If or Attending after death. I Director: Afte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		reet, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Co	(Check only 2 Medical Exam	sician: To the best of my know iner: On the basis of examination	vledge, deat on and/or in	h occurred at the t vestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	us stated. e to the cause(s)
o the ithin 2 o the	Med	29b. Signature and titlerof certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
, , , ,		> Herta			107	2651	6 1	ANUARY	13 2004
4	1	30 Name and address of person who c	ompleted cause of death (Item	23а) (Туре,		10 6	2000 00 1/1	010	71742
		31. Date filed (Month, Day, Year)	MD 1475	TA	VEY A	VE T	PEDELKI	MU	21702
S Regis	tate trar	JAN 1	5 200	wa	19	Spork.	2		

			For State Registrar	State of Marylar	•	artment of H			giene 20 (0229	13
			Decedent's Name (First, Middle,	, Last)				2. Date of Dea	ath	3. Time of Death	1
н	Physici		William Kelsie	e Puckett				Januar		^{(ear} 1800	М
	/Medic Examin		4a. Fecility Name (If not institution,			4b. City, Town, or	Location of Death		4c. County of		
			220 Merrick Co	orner Road		Church			Queen	Anne's	
П	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	Birthplace (State or Fore Country)	ign
	Director		218-20-6720	X 81	Yrs.			Oct. 24	1922	Virginia	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Lim	its
	Mary f sho	ğ	Md. Queen	Anne's	Church	Hi 11				1 ☐ Yes 2 ☐ f	No
	288 7	Director	10e. Street and Number	Thate o	Office Cit	10f. Zip Code		T	10g. Citizen of Wh	at Country?	
	within 72 hours after death with the Maryland ene. Than "natural", or itams 23e or 28e-f show ne Medical Examiner must be nutified at	O E	220 Merrick Co	rner Road		21623				USA	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	14. Race -	American Indian,	
٥	after or its		1 ☐ Never Married 2 🕅 Marri	ed 1 ☐ Yes 2 ☐ No If Yes, Give		1 □ Yes 25√No	Specify:	o moan, etc.,	Specify:	White, etc.	
2	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						White	
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	withir ane.	E G	Elementary/Secondary (0-12)	College (1-4or 5+)			/		State Hi	ohway	
Maryland 21	Hygir ther ant, I		4th 17. Father's Name (First, Middle, L	_ast)	<u> Н</u>	i.ghway	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)		
a	ed fa b	To Be	Milam Puckett				Form	nie Jane	Uabb		
2	should nd Men marke	F	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailir	ng Address (Street a			11-0-0-10	ate, Zip Code)	
	12 ha 7		Louise Puckett	•	220	Merrick	Corner R	oad Chu	rch Hill	. Maryland 2	161
altimore,	s 1 and if Healt item 2 other	1	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		Date	20c. Location - Ci		-
Ë	Pages lent of nt: If i		1 🕅 Burial 2 □ Cremation 1 □ Donatiog 5 □ Other (Sp	3 Memoval from State		ills Ceme	ı	2/200/	Degrees D	0.1 arrans	
alt	permit. Pag Department Important: It any injury o		21. Signature of Funeral Service L	jcensee .	22	Name and Address	s of Facility				
ñ	Departiment of the particular	4	Jary 13.	Illows	3	70 Cypres	s Street	α wewn . Millin	am runera oton Ma	al Home, P.A ryland_21651	. •
100	(23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	- ACUTE	MYOC	ARDIA	L. MEG	+rct10	N	Onset and Death	-
В	/Medical		resulting in death)	Due to (or as a conse	quence of):						
ă.	Examiner		Sequentially list conditions.			ANTE	RY DI	SEMSE	=	>5 yea	15
	pe tis	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):						
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):						
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687	ate hy:	dical		d							
Box	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date of	of delivery	
ğ	death e atten	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	n Day Year	
o.	t the by the ache	hys	9 Unknown	9□ Unknown							
	The law requires that the de ste has been signed by the a page 2 should be detached to	by P	Part II. Other significant conditio	ns contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribi	ute to the cause of death?	
ğ	v require been sig should b	leted t	VEMENTIA					101	'es 2 □ No 3	Probably 4 Unknow	ΝN
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Vital Records,	iicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)		
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Division of	ng Pl		27. Magner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at c?		low injury occurred		
810	eath. or: A	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation of he			Yes 2 □ No				
$\frac{3}{2}$	or Att	Certification:	4 Homicide determi			eet, factory, office		28f. Location (S City or Tox		or Rural Route Number,	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certificacompletely filled in by the funeral director.		CO- Co-Miles	- Oh side X- A- b- b- d- d- b-				4.433			
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	ithin the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (/	Month, Day, Year)	
	F 3 F 8		b the v	7 MARAV	W	D	0041		1/8	1/2004	
,			30. Name and ad ress of person v	who completed cause of death (Ite	m 23a) (Tyne	Print)		- '	1	1/	
				le, M.D. 122 Spe		•	ctorm Ma	rv1 and	21620		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		a onestel	LOWII Flo	uytaill.	<u>-1020</u>		
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					ORIGIN	AL					

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jamuary Pay 13 **Physician** 2004 1526 Betsy V. Pindell /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplece (Stete or Foreign Country) **Funeral** 1 □ M 200 F 217-38-3248 26 1939 Maryland Nov. Director 64 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show ral, or iteme 23a or 28a-f ehov Examinar must be notified at 177 Yes 2 □ No. Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 'natural', or iteme 23a 21401 USA 216 Gross Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ②No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iten any injury or other traumatic event, Ita Medical Exemin 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Co. 12th Office Clerk Anne Arundel 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be John H. Brown Carrie V. Herndon ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 216 Gross Ave. Annapolis, Md. James Pindell (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bestgate Memorial
Park Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State *4 □Donation 5 □Other (Specify) 1/20/04 Annapolis, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Reese & Sons Mortuary, P.A. West St. Annapolis, Md. 21401 Wm. 821 Wm. Reese & Sons Mortuar 821 West St. Annapolis,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition OCAR **Physician** ONE MINUTE /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown ۵ peubis 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 90 1 Yes 2 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 certificate 2 No 1 Yes 2 No 1 Yes filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: Hospital: 1 Inpatient 2 ER/Outpatient 300A 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 Ho this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide the Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the 29c. License number 29d. Date signed (Month, Dey, Year) 19b. Signature and title of certifier 14 2000 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2140 FREEDMAN MD DEFENSE HighWAG MICHASI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2004 Registrar

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			State of Mai	•	artment of F ertificate of			ene g. N2 0 () 4 (02295
	Physician	Decedent's Name (First, Middle, Lands I. A.M.E. T. A.M.E. T. A.M.E.	ast) S MARTIN PE	NNTNCTON			2. Dete of Death Month JANUARY	Dey	Yeer 004	3. Time of Death 8:05 A.M.
	/Medical Examiner	4e Facility Neme (If not institution, gi	ve street and number)		1	4b. City, Town, or Lo	cation of Death	4c. County	of Death	0.03 21.11.
	Funeral			(In yrs. lest birthday) If Under 1 Year Months Deys	OAKLAI If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Year)		ice (State or Foreign γ)
	Director	233-46-9336 Usuel Residence of Decedent		11			OCT. 7,	1926	WV	
	anylen ehow	MD 10b. County GARRET		10c. City, Town or L					100	d. Inside City Limits 1 ☐ Yes ※(N)
	28e-1	MD GARRE'I	. 1	OAKL	AND 10f. Zip Code		10	g. Citizen of W	/hat Countr	
	death with the Maryler ms 23s or 28s-f show ir must be notified at meral Director	131 BRAY SCHOO	L ROAD		21	550		USA	A	
920	or, or the	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:			lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, et	tc.
21215-0036	in 72	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	ing	6b. Kind of Bu	siness/Indu	
ng.	be filed tal Hyg d other event,	17. Father's Neme (First, Middle, Las	1)			18. Mother's Name			ө)	
Maryland	Ment Marked Marice	CLAUDIUS PEN		40h Mail	in a Address (Ctroot	and Number or Rure	VA HELMI		State 7in (Codel
Mai	d Z is	19a. Informant's Name/Relationship FREDA PENNINGTO			•	OOL ROAD,		-	1550	<i>10</i> 06)
Baltimore,	permit. Peges 1 en Depertment of Heal Important: if Itam 2 any Injury or other once.	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Speci	☐Removal from State	20b. Place of Disp cemetery, cre		сө)		Oc. Location -	City or Tow	
Balti	permit. I Depertm Importar any Inju	21. Signatur French Service Lice		2	2. Name and Addre				215	50
	Physician /Medical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	ne deeth. Do not er		ng, such as cardiac (or respiratory arres	st,		Approximate Interval Between Onset and Death WKS
	4.1	resulting in death)	D	ue to (or as a conse	equence of):					
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Box 687	- DA	resulting in deeth) Last	d	ue to (or es e conse	quence of):	10			1	
	D 00 00	Part II. Other significant conditione	contributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23b. Did tob	oecco use con	tribute to	the cause of death?
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of Vital Records,	requii						24a. Was an perform	autopsy led?	avai	re autopsy findings ilable prior to ipletion of cause eath?
- R	The law ete hes page 2						1□Yes	x□No	1 🗆	Yes 2□ No
Vita	slan: ertific sctor	25. Was case referred to medical examiner?	Hospital:		ot so Oti	nor:	h (Check only one			
on of	this el dii	1 ☐ Yes 257 No 27. Menner of Death 1 X Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey	t 2 ER/Outpetie 28b. Time Injury	of 28c. Inju	4 LANursing Ho	me 5 Resider 28d. Describe hov			
Division	To the Hospital or Attending Pi within 24 hours effer death. To the Funeral Director: Affer the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not determined	28e. Plece of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,
	he Hospital in 24 hours of the Funeral ipletely filled edical Co	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the besis of e and manner stets	xamination end/or i	th occurred at the ti nvestigation, in my o	me, date end place, opinion, death occurr	and due to the careed at the time, da	use(s) and ma te and place, a	nner as ste and due to t	ited. the cause(s)
)	To the Vithin To the Comp	29b. Signature end title of certifier	Celebra	D	29c. Licens D300			d. Date signed		ey, Year)
	N	30. Name end address of person who				<u> </u>	0-1-5	- 7	0.15	
	State	Donald R. Ri 31. Dete filed (Month, Day, Year)	32. Registrer		Memori	al Drive	e Uakla	na, MI) 215)50
	Registrar	JAN 14	2004	a the	porte					

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			For L_ Stete	State of Marylar	id / Depa		ealth and	d Mental Hy	giene 200	4 02296
		_	Registrar		00,	tineate or i	Julii	2. Date of De	Reg. No.	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)	ADOLANI IIALI	ם חווס	TT.		Month	Day Ye	ar
	/Medic			AROLYN HALI	1 KOOS			JAN 5		9:30 A
r.	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of D	eath	4c. County of D	
			9 KALTEN RD.				STMINS		CARROI	L
	Funeral		5. Social Security Number 6. Sex	3077		If Under 1 Year Months Days	If Under 24 h	Hrs. 8. Date of Bir Min. (Month, Da	iv. Year)	Birthplace (State or Foreign Country)
	Director		578-10-4246	الا جهار	36 Yrs.	·		12/15	/1917 I	LLÍNOIS
	D .		Usuel Residence of Decedent 10a. State 10b. County	100 G	ty, Town or Lo	nation				10d. Inside City Limits
	larylan show				ESTMIN					1 ☐ Yes 2 No
	Pa-fa	5	MD. CARRO	MT	POINT	DIEK				
	th th	ire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a	ai	9 KALTEN RD.			21158	3		USA	
	dea	ner	11. Marital Status	Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origin?	? (Specify Yes or No uerto Rican, etc.)	14. Race - A	merican Indian, hite, etc.
9	after or the	Ŀ	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2X No		,		
ဗ္ဗ	rel.	<u>5</u>	3X Widowed 4 □ Divorced	Year or Dates:		103 223110	эрволу.		Specify:	WHITE
20	within 72 hours after death with the Maryland ene. than "returel", or tlems 23a or 28a-f show than Medical Examinar must be notified at	jec	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation during most of	workina	16b. Kind of Busine	ss/Industry
2	thin .	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired HOUSEW			HOME MAK	מיזו
21	gien gien	Completed by Funeral Director	12	22		HOUSEW				
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<u>a</u>	Mental Merked o	Tof	JOHN	HALL			H	AZEL	WILSON	
Maryland 21215-0036	should and Men s marke umetic		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Maili	ng Address (Street	and Number o	r Rural Route Numb	er, City or Town, Stat	e, Zip Code)
	and 2 salth a n 27 is		DAVID ROUSH	- SON	9 K	LTEN RD	., WES	TMINSTER	, MD. 21	158
ନ୍	s 1 a f He item othe		20a. Method of Disposition	1 4	Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location - City	or Town, State
20	age ant o ht: If		1 ☑ Burial 2 ☐ Cremation 3 ☑R: 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State GLI	ENDALE	CEMETE	RY 1/	7/04	MIDDLEBU	RG, PA.
Baltimore,	artme		21. Signature of Funeral Service License						FUNERAL	
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			23a. Part1. Enter the disease, or complications, or heart failure. List only on	e cause on each line.						Interval Between Onset and Death
)	Physician		Immediate Cause (Final disease or condition	Progre	SSIVE	primo	nary	Fibrosis	<u>``</u>	ZWREKS
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):		1			
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ó	e be execu /sician and e burial-trar	Ä	resulting in death) Last	Due to (or as a consec	quence of):					
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99	tifica ig ph as th	Physician/Medi								
Вох	n cer andin use	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of	•
_	death e atte d for	icia	in the past 12 menths? 1 □ Yes 2 WNo	4 Pregnant at time of o		Other (specify)			Month	Day Year
P.O.	the ay the ache	lys.	9 Unknown	9□ Unknown						
	requires that the death certificat een signed by the attending phy nould be detached for use as th	by P	Part II. Other significent conditions con	tributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	tobacco use contribut	e to the cause of death?
ds	uire n sig	D D						1 🗆	Yes 2. No 3.□	Probably 4 Unknown
Ö		Completed						24a. Was	an 24b. Were	autopsy findings available
Re	The taw ate has b bage 2 s	를						auto perfo	psy prior deatl	to completion of cause of
a	n: The licate har, page							1 Yes		′es 2□ No
Ę	Physician: The taw this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	ospital:	7500	oth Oth	or:	Death (Check only		~ .
ō		10	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	IL 3 DOA	4 🗀 (40) 511		how injury occurred	pecity)
5	fter fter	io	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No			
Si	Attending r death. ector: After	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome form st			28f Location /	Street and Number o	Rural Route Number,
Division of Vital Records,	or A	Certification:	4 ☐ Homicide determined	building, etc. (Speci		est, lactory, office			wn, State)	, , , , , , , , , , , , , , , , , , , ,
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical		sicien: To the best of my kn ner: On the basis of examinand manner stated.						
	the hin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.	0	29c. Licens	e number		29d. Date signed (M	onth. Dav. Year)
	To wit		250. Signature and title of certifier	rim (Mes	Y			13	10:- 13 1	6, 2004
	1150			7	. WO		55994	٠,٥	Dougas 1	0, 200
	B-6		30. Name and address of person who co		m 23a) (Type,	Print)	3/	INPOCHES -	note at	7115
			John C. Abel, M.E		mer A	re Juste	100	44/2) 41/4	عامر (مملد:	21157
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign		/				
	Regist	ar	JAN 0 7	LUU4 /Justice	10.	Braste				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #46 per phy G828 2/19/04 tas
State of Maryland / Department of Health and Mental Hygiene Amended, 4a, pel- For State M.D., TCHD, 01/27/2004, sbb Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 0503 10 2004 Nancy Girhard Ryan January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
212 E. Chestnut Street Examiner Easton St. Michaels
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Talbot Hospital <u>Memorial</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days **Funeral** Min 1 M XXF Yrs. 79 7-21-1924 Newton, IL Director 224-60-0726 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County rai', or items 23s or 28s-f show Examinar must be notified at 12 Yes 2 □ No Director Talbot MD St. Michaels 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 212 E. Chestnut St. 21663 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Ryan, Nancy Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White þ 3 Widowed 4 Divorced Year or Dates "naturaf" er then "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiens Important: If I tem 27 is marked other the say injury or other traumatic event, Ital. ORGS. Geoologist Civil Service 11 years
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Monroe Girhard Lora Schackmann 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P. O. Box 38, St. Michaels, Md. 21663 Robert B. Ryan (husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Capitol Crematory 1-11-04 Dover, DE. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Carroll Hurley Funeral Home PC. caused the deaty. Do not enter in mode Bons, such a ser St. resett Chaels, Md. 2166 amate each line. 23a f an I. Enter the disease, or completions that shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attanding Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medlcai IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Wes decedent pregnant 3 DEctopic pregnancy Live birth 2 Fetal death Month Dav Year in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA NZ Yes 2 □ No Certification: To this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No м 2 Accident 24 hours after death Funeral Director: A 6 Could not be determined 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or one) within 2 29d. Date signed (Month, Day, Year) And of certifier 29b. Signafure and 2 1/4/04 100 44282 4410 Backdors AT REL OXFORD, MD 21651 cause of death (Item 23a) (Type, Print) 30. Name an laude KOPROWSKI

State Registrar

JAN 1 2 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20 **Physician** Jm 2004 ARRON L. RIZO /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MALLARD BAY NURSING & REHAB CENTER CAMBRIDGE DORCHESTER 8. Date of Birth (Month, Day, Year) DEC 12 1933 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours TEXAS 1 XM 2□ F Yrs. 70 464–60–4843 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthan "natural", or Itams 23a or 28a-1 shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD CAROLINE PRESTON Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4290 FRAZIER NECK RD. 21655 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene other than Elementary/Secondary (0-12) College (1-4or 5+) 12 HIGH VOLTAGE ELECTRICIAN STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fi f Health and Mental H itam 27 Ia marked otl othar traumatic aver IGNACIO RIZO MINNIE GARZA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 : Department of Health ar Important: If item 27 la any injury or other trau 4290 FRAZIER NECK RD PRESTON, MD 21655 DOROTHY L. RIZO/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 1-20-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee ress of Facility
HELFENBEIN & NEWNAM FUNERAL HOME PA FELLOWS, HELFENBEIN & NEWNAM FUNERA 200 S. HARRISON ST EASTON, MD 21601 201.6 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner S. uential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The faw requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Division of Vital Records, P.O. Box 68760 cai Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 ☐Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 212 No certificate 1 Yes within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Attanding Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 6 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of cause of death (Item 23a) (Type, Print) and address of pe solden 31. Date filed (Month, Day, Year) State Registrar

		1	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I		nd Mer		ene ₂ 00	4 02299
	ysicia	١	Decedent's Name (First, Middle, Last) George Whiting F	Pavmond				2.	Date of Death Month	Day 2004	3. Time of Death 930pm M
	Medica camine	r	A. Facility Name (If not institution, give s MEBA Engineering	reet and number)		4b. City, Town, C		Death		4c. County of	
Fun Dire	eral ector	:	5. Social Security Number 6. Sex	7. Ag	ge (In yrs. last birthday 53 Yrs.		If Under 24	Min.	Date of Birth (Month, Day, Y	(ear) 9	Birthplace (State or Foreign Country)
g			Jsual Residence of Decedent 10a. State 10b. County		10c. City, Town or L						10d. Inside City Limits
th the Ma or 28a-f s	a notifies	lrecto	MI. Chippewa 10e. Street and Number	à	Sault Sa	10f. Zip Code	rie		100	. Citizen of Wha	M ☐ Yes 2 ☐ No at Country?
5-0036 72 hours after death with the Maryland neture!', or items 23e or 28e-! show	andher cust b	Funer	2442 East 3 mile 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes Give A	Ever in U.S. 13	4978 Was Decedent of If Yes, specify Cub 1□ Yes 2□No	Hispanic Origin an, Mexican, F	n? (Specify Puerto Ric	y Yes or No- an, etc.)		American Indian, White, etc.
21215-0036 ad within 72 hours atlegiene.	other traumatic event, the Madical Examiner must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or	5+) (Giv	adent's Usual Occu e kind of work done DO NOT use retire ne Engi	during most o d)	of working		Sb. Kind of Busin	•
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Baltimore, Mi sermit. Pages 1 and 2 Department of Health a	ıry or other tra		Kate Raymond 20a. Method of Disposition 1	emoval from State	cemetery, cri	osition (Name of Pamatory or other pla	ice)			inte d over, D	
Baltimor	any injury once.		21. Signature of Funeral Service License	1/ 1/1	a kear	R. Carr	oll H				
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3760, ate be executed by sician and	ne bu	cal Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a consequence of):						
. To o	detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	÷y			23d. Date of Month	
T ta to	p eq .	ò	Part II. Other significant conditions con	tributing to death I	but not resulting in the	underlying cause g	ven in Part I.				ute to the cause of death?
I Rec The law	page 2 should	Completed							24a. Was an autopsy performe	prio ed? dea	re autopsy findings available or to completion of cause of ath? Yes 2 ANo
Vision of Vital F Attending Physicien: Th r death.	funeral dir	atlon; To Be	25. Was case referred to medical examiner? 127 Yes 2 No 27. Manner of Death 127 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpati 28a. Date of Inj (Month, Da	ient 2 ER/Outpati ury 28b. Time ay Year) Injury	of 28c. Inju	her: 4 ☐ Nurs	sing Home 28d			(Specify) M たなけ
Division of or Attending after death.	d in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	njury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f.	Location (Stre City or Town,		or Rural Route Number,
Division To the Hospitel or Attent within 24 hours after deatt	letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ner: On the basis and manner s	t of my knowledge, dea of examination and/or stated.	ath occurred at the investigation, in my	ime, date and opinion, death	place, and occurred	d due to the cau at the time, dat	ise(s) and mann e and place, and	er as stated. d due to the cause(s)
To the within 2	comp	Ĭ	29b. Signature and time of certifier	lope	wh Me		se number 6 4428	2		d. Date signed (1	Month, Day, Year)
			30. Name and address of person who co	or role i	4410 Bac		. Oxfo	ord.M	1D.216	5.4	
R	Stat egistra	e ar	31. Date filed (Month, Day Year)	2. Regist	trar's Signature	M.					

		•	For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artmen			and M		giene Reg. No. 20 (02300
			Decedent's Name (First, Middle, La	st)							2. Date of De		3. Time of Death
	Physicia /Medic		Hilda Marie Rale	ich							Januar		7:30 A M
	Examin		4a. Facility Name (If not institution, given	e street and nu	mber)		4b. City,	Town, or	Location of	of Death		4c. County of 0	Death
			Chester River Ho						town	0.4 Hen	0.0	Kent	5:::
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4	Director		217-52-0038 Usuel Residence of Decedent			85 Yrs.					March	0, 1910	Maryland
	yland yland		10a. State 10b. County		1	Oc. City, Town or L	ocation						10d. Inside City Limits
	a-1-a	Director	Md. Kent	,		Cheste	ertown	l .					1 XYes 2 No
	or 28	Olre	10e. Street and Number				10f. Zip					10g. Citizen of Wha	
	ath w		23098 Raleigh Ro			1-110		2162		nin0 /0-	- At - Van an Na	USA	American Indian,
	er de Items ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dec		or in U.S. 13.	If Yes, spec	ify Cuba	n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	Black, V	White, etc.
336	hours after death with the Maryland turet, or Items 23a or 28a-f show at Examiner mast te notilised at	by	3 Widowed 4 □ Divorced	If Yes, G Year or I	ive ~ ~		1 🗆 Yes	2 X No	Specify:			Specify:	White
21215-0036	be filed within 72 hours after death with the Marylar Hydiene. do ther than "natural", or Nems 23a or 28a-1 ahow avant, the Medical Examinating the notified at	ted	15. Decedent's E (Specify only highest gr	ducation	1	16a. Dece	edent's Usua e kind of wo	I Occupa	ation	t of worki	ina	16b, Kind of Busin	ess/Industry
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21	ygien ygien her th		12th	()		Homema	ker	19 Mothe	ode Name	/Eiret Middle	Own Hom Maiden Sumame)	e
and	2 should be filed and Mental Hygis la marked other aumatic avant, II	Be	17. Father's Name (First, Middle, Las	,				177				Eliason	
2	hould d Me mark matic	우	Clyde Thrift 19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ina Address	(Street a				er, City or Town, Sta	ate, Zip Code)
Σ	od 2 sho lith and 27 la m r traum		Clyde Albert Ral			100							land 21620
ē,	s 1 ar f Hea item other		20a. Method of Disposition			20b. Place of Disp cemetery, cre					Date	20c. Location - Cit	
Ē	Pages nent of int: # it iry or o		1 TBurial 2 ☐ Cremation 3 (14 ☐ Donation 5 ☐ Other (Special		State	Chester			1	1/15	/2004	Chesterto	wn, Maryland
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marks any injury or other traumatic <u>once</u> .		21. Signature of Funeral Service Lice	lelfen	bei					hbei , Che	n & New esterto	nam Funer wn, Maryl	al Hôme, P.A. and 21620
E			23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	plications that one cause on	each, line.								Approximate Interval Between Onset and Death
ħ.	Physician /Medical		disease or condition resulting in death)	a. Due to	Corasac	onsequence of):	mele	ne /	inc	uen	any c	lisease	years
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6876	physic the b	dlcai	•	d									
× 6	ding	/Me	IF FEMALE:	23c. If yes, o	utcome of	pregnancy						23d. Date o	of delivery
Вох	leath atter	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq\) Yes 2 \(\subseteq\) No	4∏Preg	nant at tin		□Ectopic pr □ Other (sp					Month	
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	The law requires that the death certifica sie has been signed by the attending ph age 2 should be detached for use as th	Completed by Physiclan/Med	Part II. Other significant conditions	contributing to	death but	not resulting in the	underlying o	ause give	en in Part I			_	ite to the cause of death?
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Records,	as 2	ple	@ Penplus	al a	ter	al Di	1200				24a. Was autor	osv prio	re autopsy findings available r to completion of cause of
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Division of	Atter er dea ector by the	Certification:	3 Suicide 6 Could not determine	4 200. Flat	e of Injury	- At home, farm, s	treet, factor	, office			28f. Location (. City or To		or Rural Route Number,
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical		minar: On the		xamination and/or i						cause(s) and manne date and place, and	er as stated. If due to the cause(s)
	To the within To the comp	×	29b. Signature and title of certifier				29	-	e number	13		29d. Date signed (/	Month, Day, Year)
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			30. Name and address of person who		use of dea			1	0	, ,	estown	10.	7 21-
			31. Date filed (Month, Day, Year)	32	Segistrar	Signature	lon 1	tue.	100	est	everyn	- viri	2620
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		State of Maryland /	Department of Health and M			
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Phys /Me	ician dica			2. Date of Death Month January 2) 2004 Year	3. Time of Death $10:00 \text{ pM}$
Exan		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
		Chester River Manor 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Chestertown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Kent 9 Birthol	ace (State or Foreign
Funer Directo		218-80-8256 1 M 2 F 80	Yrs. Months Days Hours Min.	(Month, Day, Yea Oct. 5, 19	923 Mar	ace (State or Foreign try) cyland
yland		10a. State 10b. County 10c. City, Tow	n or Location		10	Od. Inside City Limits
e Mar 3e-fs	Director	Md. Kent Ch	estertown			1 ∏Yes 2 ☐ No
with the	2		10f. Zip Code		Citizen of What Coun	try?
feath ns 23	Funeral	200 Morgnec Road 11. Marital Status 12. Was Decedent Ever in U.S.	21620 13. Was Decedent of Hispanic Origin? (Spinf Yes, specify Cuban, Mexican, Puerto		JSA 14. Race - America	an Indian,
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland the Hygiene. d other than "naturel", or items 23e or 28e-f show event, I be Medical Examinar must be notified at	74 11.74	3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 📉 No Specify:	Rican, etc.)	Black, White, e	ite.
72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	16b.	Kind of Business/Ind	
Maryland 21213-UU35 d 2 should be filed within 72 hours af th and Mental Hygiene. ?? is marked other than "naturel", or treumatic event, the Madical Exam	a de	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)			
filed v Hygie Sthert	Š	7th 0	Homemaker 18. Mother's Name	(First, Middle, Maide		Home
d be ontal ked o	S C			burn Jeste	ŕ	
arylar should be and Menta s marked umatic ev			D. Mailing Address (Street and Number or Rura			Code)
and 2 and 2 auth a			23240 Buck Neck Road,			
SAITIMORE, Dermit. Pages 1 ar Department of Hea Importent: If item: any injury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of cemeter	of Disposition (Name of Information of Information of Information of Information of Information (Name of Informati	Date 20c.	Location - City or To-	wn, State
t. Pag trmen trent: rient:			eterans Cemetery 1/6/	2004 Hui	clock, Mar	y1and
Baltimore, Marylal permit. Pages 1 and 2 should be Department of Health and Menta Importent; If item 27 is marked any injury or other treumatic €	8000	21. Signature of Funeral Service Licensee Hith Af African Service Licensee	22. Name and Address of Facility Fellows, Helfenbein 130 Speer Road Ches	& Newnam tertown, N	Funeral H Maryland 2	ome, P.A. 1620
		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death,
Priysicia /Medic		Immediate Cause (Final disease or condition resulting in death)				1 week
Examine		Due to (or as a consequence	of):			
	ةِ ا	Sequentially list conditions, if any, leading to immediate cause. Extra light to immediate cause.	of):			
ocuted nd transi	Fyaminer	if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events				
ate be executed sysician and he burial-transit	ů.		of):			
oo/ ificate t g physia as the b	iesiles					
BOX 68, leath certificate attending phy	M/d	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	y
the death y the atte	Completed by Physician/Med	in the past 12 months? 1	3 □ Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
cords, F.O. wrequires that the de been signed by the a should be detached	2	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the	
PTG requir sen si nould l	Pat	Word WA will let Herripa	usis. & Semle	1 Tes	2 ID∕No 3 ☐ Proba	ably 4 □Unknown
he law requires the has been signed age 2 should be considered.	alga	Demention 3) 14 pe IT DM	DHIV. Dage	24a. Was an autopsy performed?	prior to com	sy findings available pletion of cause of
alr n: Th ficate f. pag	Č		(B) Sendity	1 Yes 2		2□ No
Of VICAL He Physicien: The la r this certificate ha ral director, page 2	L R		Othor 37	n (Check only one)	6 □Other (Specify	
on or ding Phy h. After thii funeral o	<u>ا</u>			28d. Describe how inj		
Vittendin death. ctor: Af y the fur	at c	1 Length 1 L	M 1 Yes 2 No			
UIVISION OI lor Attending Phy after death. I Director: After this d in by the funeral d	Certification.	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural te)	Route Number,
DIVISION Of VITAL RECORDS, P.O. BOX 58 To the Hospitel or Attending Physicien: The law requires that the death certifica within 42 hours after death. To the Funese Director: After this certificate has been signed by the attending phrompiletely filled in by the funeral director, page 2 should be detached for use as it	Modical		e, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause(ed at the time, date a	s) and manner as stand place, and due to	ited. the cause(s)
To the Within To the	M		29c. License number		ate signed (Month, D	Day, Year)
		164. Clim , MD.	021313		15/04	
		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	lesterton	n, Ind	21620
	State istrar	31. Date filed (Month, Day, Year) 32. Regionar's Signature	4 Species			

			For State Registrar	State of	Marylan		artment of tificate of			ental Hygie	ene . No. 20 (02302
	Physici		1. Decedent's Name (First, Middle, L. Shirley M		binson					2. Date of Death Month Jah war y	Day 20	ear	3. Time of Death A
	/Medic Examin		4a. Fecility Name (If not institution, gi				4b. City, Town	n, or Location of		7	4c. County of	Death	
	Funeral			Sex	tal 7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da	ar If Under	24 Hrs. 8	B. Date of Birth (Month, Day, Y	9		ace /State or Foreign
45. , <u>20</u>	Director		218-34-3488 Usual Residence of Decedent	1□ M 2 XF	66	Yrs.	World St	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		UG. 1, 1		ry1	
	nyland how		10a. State 10b. County	+ an	[y, Town or Lo						10	Od. Inside City Limits
	he Ma	Director	Maryland Washing		F	airpla				1.00	091		1 ☐ Yes 2 🛣 No
	3a or 3	i	17801 Spielma:	n Road			10f. Zip Cod	.733		100	. Citizen of Wha United		
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, Ite Medical Examera must be redified at once.	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 XX/idowed 4 Divorced	12. Was Deced Armed For 1 Tes If Yes, Give Year or Da	ces? 2 ሺ No e	1	Was Decedent of Yes, specify C			ify Yes or No- ican, etc.)	14. Race - Black, Specify:	White, 6	
21215-0036	ithin 72 hou ie. ien "natura i Medical E.	Completed I	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	ducation rade completed) College (1-		(Give life. (dent's Usual Oc kind of work do DO NOT use re	ne during mos. tired)	st of working	7	b. Kind of Busin	ess/Ind	lustry
7	iled wi		17. Father's Name (First, Middle, Las	0		Но	memaker	Ţ	er's Name /	First, Middle, Ma	her own		
Maryland	Mental I	To Be	Frank Leo							Mazie Da			
lary	2 should and Men is marke sumatic	Ξ ₁	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Stre	eet and Numbe	er or Aural	Route Number, C	ity or Town, Sta	ite, Zip	Code)
	1 and Health em 27		Audran Robinson 20a. Method of Disposition	dauş	ghter 20b. F	lace of Disno	sition (Name of		d, Fa:	irplay,	Marylan c. Location - Cit		
DE L	Pages nent of I int: If it		1 ØBurial 2 ☐ Cremation 3 6 4 ☐ Donation 5 ☐ Other (Spec				matory or other Memori		1-14				, Maryland
Baltimore,	permit Departm Importa any inju	1	21. Signature of Funeral Service Lice	ensee			Name and Ad			nnich Fu , Hagers			land 21740
3			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ca y one cause on ea	used the deat	h. Do not ente	er the mode of	dying, such as	cardiac or	respiratory arrest	,		Approximate Interval Between Onset and Death
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	Examiner		Sequentially list conditions.	b. mu	eti a	estes	no ou	gan &	Julia	ر کا			
	led nsit	Examiner	cause (Disease or injury	Cilia to (d	peanon is as to	uence of):		6					
Ć.	execut an and rial-tran	Exar	that initiated events resulting in death) Last	c. Due to (c	or a a conseq	ueace of):	0 10	4					
8760,	cate be executed physician and the burial-transit	dicai		o. Cle	elrid	Man	Colit	is				4	
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta unt at time of d	Ideath 3	Ectopic pregna Other (specify				23d. Date o Month		ry Day Year
_	that the	y Ph	Part II. Dther significent conditions	contributing to de	ath but not res	ulting in the ur	nderlying cause	given in Part I.		23e. Did tobac	co use contribu	te to th	e cause of death?
rds	w requires l been signe should be	ed by								1 ☐ Yes	2 □ No 3[] Proba	ably 4 Unknown
Vital Records,		Completed								24a. Was an autopsy performed	d? deat	e autop r to com th? Yes	esy findings available apletion of cause of
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		5D/0.4		Other		Check only one)			
Division of	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director, it	ation: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date o		28b. Time of Injury	28c. In	ijury at Vork?	28	e 5 Residence d. Describe how		Specify,	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not 4 Homicide determine	289. Place	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, stre	et, factory, offi	ce	28	of. Location (Street City or Town, S		r Rural	Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1- Certifying P	hysicien: To the miner: On the ba and mann	sis of examina	wledge, death	occurred at the restigation, in m	e time, date an ny opinion, dea	id place, an th occurred	d due to the caus at the time, date	se(s) and manne and place, and	r as sta due to	ited. the cause(s)
	To the within 2 To the Complet	Mec	29b. Signature and title of certifier	GETTEL STEEL	o. stateu.		29c. Lici	ense number		29d.	Date signed (A	fonth, E	Jay, Year)
)	6		1 Permin	·Con			I	3828	5		1/12/	04	
X	X´		30. Name and address of person who	completed cause	of death (Item	n 23a) (Type,	Print)	11	1	est 1941	s sāve	u -	
	Sta	te	31. Date filed (Month, Pay, Year)	2004 32.7	gistrar's Signa	iture	eifer	, C	7.10	1	- 00.1	1	
	Registr	ar	ONN TO	LUUT C	The state of	N. 100							

				•	State of Maryland	/ Departme	nt of Health and Nate of Death	_	ne 200	4 02303
				Decedent's Name (First, Middle, Last)	~			2. Date of Death	Day Year	3. Time of Death
		Physici /Medio		JULIA ELIZABETH F	ROBERTSON			January	10, 2004	10:35 AM
		Examin		4a. Facility Name (If not institution, give stre REEDERS MEMORIAL HO	OME		y, Town, or Location of Death BOONSBORO			HINGTON
		Funeral Director		5. Social Security Number 577-26-2700 Usual Residence of Decedent	7. Age (In yrs. las	Yrs. If Und	ler 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth Month, Day, Yo	1912	thplace (State or Foreign out V) MARYLAND
		yland		10a. State 10b. County	10c. City,	Town or Location		- Children		10d. Inside City Limits
1		death with the Maryland ims 23a or 28a-f show Frinst be rightlind at	Director	MARYLAND WASHIN	NGTON	104.3	BOONSBORO	100	Citizen of What C	1 XYes 2 No
		with t	Dir	143 S. MAIN STREET		101. 2	21713	109		S.A.
à		death ms 23	Jera		. Was Decedent Ever in U.S.	13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Am	erican Indian,
3	21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23a or 28a-1 show or other than "natural", or items 23a or 20a-1 show event. The Medical Examinatings is a relitived at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		2 No Specify:	ricall, etc./	Black, Whi	WHITE
pe	5-0	72 hc natur	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Decedent's Us (Give kind of v	sual Occupation work done during most of work use retired)	king 161	o. Kind of Business	s/Industry
\mathcal{Q}	121	within ene. than	g m	Elementary/Secondary (0-12)	College (1-4or 5+)		TRATIVE ASSIS	-	FEDERAL	GOVERNMENT
		illed Hygi other	BeC	17. Father's Name (First, Middle, Last)		тришить		e (First, Middle, Mai		
2	/lan	Mental Mental arked o	To B	FREDERICK J. OFFUT	Γ		LULA B	EATRICE H	EFFNER	
F	Maryland	and and sum		19a. Informant's Name/Relationship (Type ROBERT N. ROBERTSO		•	ss (Street and Number or Rui ENSBURG ROAD,		•	Zip Code) 25401
9	altimore,	m O .	F	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Rer	20b. Pla	ce of Disposition (N	lame of r other place)		c. Location - City or	Town, State
JME	Ē	Page ment c ant: If		* 4 ☐ Donation 5 ☐ Other (Specify)	SM		CREMATORY1/12,	/2004 SM	IITHSBURG	, MARYLAND
2	Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Financi Service Licenses	man	BAST	and Address of Facility FUNERAL HOME	POONSPO!	D NATIONA RU, MARYL	
		Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final	ations that caused the death. cause on each line.	Do not enter the m	ode of dying, such as cardiac	or respiratory arrest Strokes)		Approximate Interval Between Onset and Death
	7	/Medical		disease or condition resulting in death)	Due to (or as a conseque		CICCIDAINS C	- cokes)		341.5
	п	Examiner	L	Sequentially list conditions, b.	Attwosel	erosis				years
		ed nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	6	escouelli	Lu			Weard
		e be executed /sician and e burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque		rus			Toris
	760,		ca	L d.						
	89 X	ertifica ling ph e as th	Med	IF FEMALE:	. Muse subsemple for section					
	O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certificate twithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the t	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	 If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deaged 9 ☐ Unknown 	death 3 □Ectopic			23d. Date of de Month	Day Year
	Division of Vital Records, P.O.	uires that t ı sign e d by Id be detaı	d by Ph	Part II. Other significant conditions control	ributing to death but not result AMSLEM	ting in the underlying	g cause given in Part I.			o the cause of death?
	000	s beer s shou	olete	Deme	entra			24a. Was an	24b. Were a	utopsy findings available completion of cause of
	l Re	The la ate ha page 2	Completed	beggi	rerative a	starch	ŝ	autopsy performe 1 ☐ Yes 2 €	d? death?	s 2 No
	/ita	cian: sertific ector,	Be	25. Was case referred to medical examiner?	spital:		Other	th (Check only one)		
	of	Physic rthis c ral dir	5	1 ☐ Yes 2 ☑ No Ho 27. Manner of Death	1 Inpatient 2 E	R/Outpatient 3 28b. Time of	DOA 4 Mursing He 28c. Injury at Work?	ome 5 Residence 28d. Describe how		ecify)
	on	ding th. : Afte	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
	Divisi	after dea Director	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)		ory, office	28f. Location (Stree City or Town, S	et and Number or F State)	lural Route Number,
		Hospita 24 hours Funeral etely fille	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my know er: On the basis of examination and manner stated.	ledge, death occurre on and/or investigati	ed at the time, date and place, on, in my opinion, death occur	, and due to the caus rred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
_		To the within To the comple	Me	29b. Signature and title of certifier		2	29c. License number		Date signed (Mon	
		,		+ Fay			D44996	J	anuary	10,2004
		LIX 5		30. Name and address of person who com Dr. Ilalik 2031in	npleted cause of death (Item :	23a) (Type, Print)	MD 21713/301-	-432 - 8470		
			ate	31. Date filed (Month, Pay, Year) 2 20	32. Registrar's Signatu					
		Regist	rar	OWN TW 70	UT MORRISON /	O' BYDEAG				

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 9,2004 January 8:50 p^M HILDRED PEARL ROOT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Grantsville Garrett Goodwill Mennonite Home If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 XX 222-28-4565 91 Yrs. 10/5/1912 Director WV Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic svent, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Director MD Garrett Grantsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 891 Dorsey Hotel Road 21536 U.S. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à Specify: White 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hotel owner Hotel/Service 12 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Ark Reese Edward Reese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 215 Maple Street, Terra Alta, WV 26764 Barbara J. Root 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation ↑ 5 □ Other (Specify) 1/13/2004 Terra Alta, WV Terra Alta Cemetery 21. Signature of heral Service 22. Name and Address of Facility, Arthur H. Wright Funeral Home 105 Highland Avenue, Terra Alta, WV 2676 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (evebra) vascular acci den **Physician** Mrombotic week /Medical Due to (or as a consequence of): Examiner nextension 40 years Social thely list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to r s a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical use as 1 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown certificate has been signed rector, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physician: Within 24 hours after death.
To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 Kulan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) margaret ka.
31. Date Hed (Month, Day, Year) 13079 Kaiser md 32. Regietrar's Signature State JAN 14 2004 Registrar

			1 - For State Registrar	State of	Marylar		artment of H		d Mental Hy	giene Rag. No. 20 (0230	5
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, 4a. Eacility Name (If not institution,	M	\mathbb{R}^{0}	ess	4b. City, Town, or	Location of D	2. Date of De Month	/ - 4	Yeer 3. Time of Death	М
	Funeral Director		5. Social Security Number 213–24–0105 Usual Residence of Decedent	Genero 6. Sex 1 M 2 M F	20 HC Age (in yrs/ 75	P (fal last birthday) Yrs.	If Under 1 Year Months Days	MON If Under 24 I Hours N	Hrs/ 8. Date of Bir Airl. Feb. 1	(Do)	9. Birthplace (State or Forei Maryland	ign
S	with the Maryland e or 28e-f show	irector	10a. State 10b. County Maryland Dorch 10e. Street and Number		10c. Cit	y, Town or Lo Cambr	idge 10f. Zip Code			10g. Citizen of Wh	10d. Inside City Limi 1 ☐ Yes 2 🛣 N nat Country?	
36 Lek	n 72 hours after death with the Marylan "neturel", or tlems 23e or 28e-f show edical Exaciliter rast be redified at	by Funeral [5530 Bonnie Bro	12. Was Decede Armed Force	No No			21613 spanic Origin? n, Mexican, Pi Specify:	? (Specify Yes or No uerto Rican, etc.)	USA 14. Race- Black, Specify:	American Indian, White, etc.	
21215-0036	e filed within 72 hou il Hygiene. other then "neture vent, the Mudical E	Completed by Funeral Director	(Specify only highest Elementary/Secondary (0-12)	S Education grade completed) College (1-40)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired, DEAGET	uring most of		16b. Kind of Busi Electro Manfacti	nic nic uring	
Maryland	2 should be and Menta Is marked eumatic ev	To Be	17. Father's Name (First, Middle, L James Mowbray 19a. Informant's Name/Relationshi Deborah R. Tod	ip (Type, Print)		19b. Mailin	g Address (Street a	O]	Name (First, Middle, Livia Harr Rural Route Numbe , 5610 Bri	ington	an New Market,	
Baltimore, I	Living Pa		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	3 □Removal from Sta	20b. F	Place of Dispo cometery, crem Vetera	sition (Name of natory or other place ans Cemete	ery 1/	Date 12/2004	20c. Location - Ci	ity or Town, State	
Ba	permit. Departr Importe eny inje	W 9	21. Signartife of Funeral Service L 23a. Part 1 Enter the disease, of castions, or heart failure. List of	ARI WY	MUL sed the deat n line.	<i>PEP</i> 0/30)8 Hi⊘h St	Can	Funeral Honbridge, Malac or respiratory and	n 21613	Approximate Interval Between	
	Tale be executed with the purial transit in the burial transit in	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a conseq	uence of):	ent For	Diech	ety		Onset and Death The Years Hen your	\(\begin{align*} \begin{align*} \beg
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	- 1-2- 1/2		23d. Date of Month	•	
Records, P.	w requires that been signed b should be deta	Ď	Part II. Other significant condition	s contributing to death	n but not res	ulting in the ur	derlying cause give	n in Part I.		_	ute to the cause of death?	/Π
Vital Rec	ilcien: The law certificate has b rector, page 2 st	e Completed	25. Was case referred to medical					26 Place of [24a. Was autop perfo	prior prior dea 2.00 1	re autopsy findings available to completion of cause of ath?	le
of	ling Phys n. After this tuneral di	sation; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursin	g Home 5 ☐ Resid		(Specify)	
Divis	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the I	Il Certification:	3 ☐ Suicide 4 ☐ Homicide 29a. Certifier 3 ☐ Certifying	286. Place of	etc. (Specify	y) 	eet, factory, office	o date and pla	City or Tou	n, State)	or Rural Route Number,	
•	To the Hospitel or within 24 hours after To the Funerel Dirc completely filled in I	Medical	(Check only 2 Medical E 29b. Signature and title of certifier 20b. Name and address of person w	xaminer: On the basis and manner	s of examina stated.	tion and/or inv	estigation, in my op	inion, death o	ccurred at the time,	pause(s) and mannidate and place, and place, and place, and place, and place signed (A	d due to the cause(s)	
	Sta Registr	_	Vinodrai Mehta 31. Date filed (Month, Day, Year)	402 Bryn Si 32. Regis		Cambri		613				

			- FUI	artment of Health and M	-	ene	00000
				ertificate of Death		g. No. 4 4 4	U23Ub
	Physicia	an	1. Decedent's Name <i>(First, Middle, L</i> ast) EVELYN LUCILLE S	TEC	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al			JAN. 11	, 2004 4c. County of Death	5:15 P M
	Examin	er	4a. Fecility Name (If not institution, give street and number) ST. CATHERINES NURSING CENTER	4b. City, Town, or Location of Death EMMITSBURG		FREDER	TCK
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth		
	Funeral Director		220–18–1631 1□M 2対F 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 4/12/19	(26 MAR	place (State or Foreign htry) YLAND
			Usual Residence of Decedent		1/12/12	20 111111	1 11/11/
	ylang how		10a. State 10b. County 10c. City, Town or to				10d. Inside City Limits
	B-f-8	Ş	MD. CARROLL WESTM	INSTER			1 ☐ Yes 2X No
	if the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	be filed within 72 hours after death with the Maryland at Hygiene. A death Hygiene do the than "netural" or tems 23e or 28a-f show dother than "netural" or tems awant, the Medical Examinating months of the collins of an	-a	718 HOLLIDAY LANE	21157		USA	
	tems tems	Funeral		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
S	s afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 24 No Specify:		Specify: WHI	TE
3	72 hours after netural', or ite	80		edent's Usual Occupation	1	6b. Kind of Business/Ir	
Ċ	in 72	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ing		
7	with jene.	E	Elementary/Secondary (0-12) College (1-4or 5+)	MANAGER]	RESTAURAN	${f T}$
0	i Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M.	aiden Sumame)	
a	D 8 2 0	ToB	RAYMOND EARSY SH	ARRER MILDRI	ED ELIZA	ABETH MOR	\mathbf{T}
ary	short s ma s ma	<u>-</u>	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rura	al Route Number,	City or Town, State, Zip	Code)
Σ	s 1 and 2 shoul Health and Miltam 27 is mari			6 SCHALK RD. #2			
<u>e</u>	ges 1 it of He if itan or oth		20a. Method of Disposition 20b. Place of Di	ematory or other place)		Oc. Location - City or To	
Ē	Pages ment of ant: If it ury or o		`4 □Donation 5 □Other (Specify) NJYS V I III	E UNION CEM. 1/			
galt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	22 . Name and Address of Facility FLE			
	205 g g			54 E. MAIN ST.,			
			23a. Part 1. Enter the sease, or a prilications that persed the death. Do not e shock, or heart failure. List only one cause or each line.	nter the mode of dying, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	y tarling			16/2
	/Medical Examiner		Due to (or as a 3d sequence of):	+ 1.	N		//
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	more My	, Dr	slore	10 yes
ī	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury	(7	1	O
	be executed sician and burial-transit	Examiner	that initiated events c				
3		cail					
ĝ			9.				
X Q R	h car endin	N/UE	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	•
	the death certifica y the attending ph sched for use as tt	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
j	at the de by the a stached	by Physician/Med	9 LJ ONKNOWN				
Ś	The law requires that ate has been signed b age 2 should be dete	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to t	
ecords	een s nould	Completed	Danielas Marins		1	2 10 3 7 70	
ပ္ မ	elaw hasb je2st	npie	yellenna		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
r =		Co	Dementia		perform	ed? death? No 1 Yes	2□ No
Vital	aician: The certificate he rector, page	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
5	this aid	. To	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ant 3 DOA 4 Nursing Ho	me 5∐Residen 28d. Describe how	ce 6 Other (Special	(y)
	ding h. After fune	tion	1 Monatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	Attan deat ctor: y the	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s			et and Number or Rura	al Route Number,
2	after Dira	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospitel or Attanding Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Physicien: To the best of my knowledge, dea	ith occurred at the time, date and place,	and due to the cau	ise(s) and manner as s	tated.
	n 24 he Fu pletel	Medical	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurr			
	To the complete th	Σ	29b. Signature and title of certilier	29c. License number	290	d. Date signed (Month,	Day, Year)
	111		· Watoudl	N) DIR 103		1115/00	1
	10.3		30 Name and address of person who completed cause of death (Item 23a) (Type	Print) A. a. B.	itsbur	AA A	21727
			Alan Carroll MD 3105, Seto	n soc kinn	1117 0040	1110	21727
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 3 2004			•	
	negisti	ui	DAIN I O COUR PRESENCE IS	Coast.			

DHMH 17 Rev 1/2001

ORIGINAL

Amended Item 23a Part I & II per Physician 01/07/2004 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	aryland			nt of H		and M		ene	04	02	307
			1. Decedent's Name (First, Middle, Last)								2. Date of Death	1		3. Time of	Death
	Physici /Medic		HAZEL	LENA	SPA	RKMA	N				JANUAR	Y 2,20	94	2:30	АМ
*	Examir		4a. Facility Name (If not institution, give s				4b. City	, Town, or				4c. County of	Death		
	37.7		Frederick Memor 5. Social Security Number 6. Sex	•	ital ge <i>(In yrs. I</i> a	ad to lead to the colo	If Linds	Fre er 1 Year	derid			1		ick	
	Funeral Director		216-38-1085	M 21 F	82	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day, Sept. 29	, 1921	Ker	olace (State on otry) otucky	or Foreign
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City	Town or Lo	cation						1,	I Od. Inside C	its Limite
	Maryl f sho	lor	Maryland Freder	ick	,		Key	mar						1 🗌 Yes	•
	r 28a	Director	10e. Street and Number					p Code			10	g. Citizen of Wh	at Cour	ntry?	
	h with	al D	11528 Renner Rd					2175	7			- 11	S.A		
	ems erms	Funeral	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S	. 13.	Was Dece	edent of His	spanic Orig	gin? (Spe	city Yes or No- Rican, etc.)	14. Race		an Indian,	
326	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural", or Itams 23a or 28a-f show marked other than "natural", or Itams 23a or 28a-f show marked other than "balless" in Itams	by Fu	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			1 □ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,	,,	Specify:		hite	
215-0036	2 hou	ted	15. Decedent's Educ	ation		16a. Dece	dent's Usi	Jal Occupa	tion		1	6b. Kind of Busi	ness/In	dustry	
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or !	5+)	(Give life. L	kind of w DO NOT i	ork done di use retired)	uring most	of working	ng			,	
21	filed wi Hygien ther th	Con	11				hom	emake				own h			
Maryland	ed at b	Be	17. Father's Name (First, Middle, Last) Harrison Blair								(First, Middle, M	,			
2	should nd Mer marke imaric	ဥ	19a. Informant's Name/Relationship (Typ	na Print)		10h Mailin	a Addrag	s (Stroot a			Maggaro		-4- 7:-	0-1-1	
	s 1 and 2 should I Health and Mer item 27 is marke other treumatic		Furman Sparkman/ s				_	nner			ymar, MD		ate, ∠ip	Code)	
altimore,	of Hear of Hear rothe		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Na	me of other place	,)			Oc. Location - C	ty or To	wn, State	
Ĕ	nit. Pages artment of l ortent: If it injury or or		1 Ø Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Tabo			·	/5/2	004 F	locky Ri	dae	. MD	
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Furreral Service License	1 X /	50	/		nd Address		Ha	rtzler F	uneral	Home	e	
	005 8 0	-	atharine	, yar	200			S. Ma			Woodsbor		179		
	Dhysisian		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	e cause on each li	ne.	Do not enti	o tine mo	de or dying	, such as o	ardiac of	r respiratory arres	1. A 15 Ad	م	Approximate Interval Bets Onset and I	ween
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a conseque	ence of):	esu	nai	100	-l	Ty.	1000	7 4 4		
	Examiner		Sequentially list conditions	con	gest	The	hee	ut	Agen	lu	ve,+	TN			
	sit ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):	0 1	f	VA	- 100	11011	1			
_	and I-tran	Examine	that initiated events c. resulting in death) Last	Due to (or as	a conseque	V(V)	XA	enu		1 W	urysi				
09/8	cate be executed physician and the burial-transit			Co	PD	1	121	441	Lie		JPC)	117	1		
200	ificate g phy: as the	edical	0.			1					1.0				
XOD	death certifii e attending p od for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome 1 Live birth			l-manin -					23d. Date of	f delive	ry	
-	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Ectopic p Other (s					Month		Day Y	ear
5	d by t	Phy	9 ☐ Unknown Part II. Other significant conditions cont			ta a ta Maria					00. 011.1				
Mecords,	requires that the een signed by th hould be detache	ρ	Anemia; HTN; Deme			ing in the un	iaeriying (ause giver	ın Part I.			cco use contribu	ite to th □ Probi		nknown
Ö	v requ been shoul	letec	,,				-			_	-				
ě	2 2 2	ompleted									24a. Was an autopsy performe	prid	r to con	osy findings a appletion of ca	ivailable luse of
VIII	en: T tificat for, pa	O .	25. Was case referred to medical				_		OC Diago	of Dooth	1 Yes 2	3No 1 1	Yes	2□ No	
	> 0	0 8	examiner?	spital:	ent 2 EF	P/Outpatient	3 D	Other			(Check only one) ne 5 ☐ Residen	e 6 ∏Other	Specific	1	
0	ng Phys ter this neral di	n:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui		8b. Time of Injury		28c. Injury a Work?			8d. Describe how		Ороспу	,	
0	endir eath. or: Af he fui	atic	2 Accident investigation	(, , , ,	iiijai y	М		es 2□N	0					
DIVISION	or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At hom- c. (Specify)	e, farm, stre	et, factor	y, office		2	8f. Location (Stre City or Town,	et and Number (State)	or Rural	Route Numb	997,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physi	cian: To the best of	of my knowle	edge, death	occurred	at the time	, date and	place, au	nd due to the cau	se(s) and mann	er as ste	ated.	
	n 24 t n 24 t he Fu sletely	edical	(Chec. only 2 Medical Examine one)	er: On the basis of and manner sta	examination	n and/or inv	estigation	, in my opi	nion, death	occurre	d at the time, date	and place, and	due to	the cause(s)	
	To the comp	ž	29b. Signature and title of gertifier	11.	116	1814	1	c. License		. ,		. Date signed (A	fonth, E	Day, Year)	
	MSL		D-160 6	MI), /	107		Do	030	14	28	1/5/	0	7	
	3		30. Name and address of person who com Sabiha Mohiuddir			3a) (Type, F	,	۰. ۸.	_	г		WD 017	04		
	Sta	e	31. Date filed (Month, Day, Year)	-	ar's Signatur		nous	se AV	٤.	۲r	ederick,	MD 217	UΊ		
	Registra		JAN 0 7 2			1	1	4							

ORIGINAL

	_1	For State Registrar	eran e o	State of Ma	-	Certifica			10	P. Date of Dea	eg. No.	2004	3. Time of
nysicia	n	1. Decedent's Name (First, M		7						Month	Ol Day	2004 Year	2015
Medica	al -	Goldie Roma				45 035	T	I continu		Jan		County of Dea	
xamine	er	4a. Facility Name (If not insti						Location o			40.	Carro	
		Carroll Hos 5. Social Security Number	6. Sex		(In yrs. last birt		r 1 Year			. Date of Birth			rthplace (State o
eral ctor		199-05-5150		M 2⊠F		rs. Months		Hours	Min.	Date of Birth (Month, Day March	13°1	.915 a	ountry) PA
101	-	Usual Residence of Deceder	nt		00								
		10a. State 10b. Co	-		10c. City, Town								10d. Inside Ci
-	cto	MD C	arrol.	L [Wes	stminst	er						1 XYes
1	Funeral Director	10e. Street and Number 28 East Gre	en Sti	reet		10f. Z	p Code 211	.57		1	0g. Citiz	en of What Co USA	ountry?
į	era	11. Marital Status	1	12. Was Decedent E	ver in U.S.	13. Was Deci	edent of H	ispanic Orig	in? (Speci	fy Yes or No- can, etc.)	1	4. Race - Ame	
	by Fur	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	0	1 Tes, sp		Specify:	, rueno m	can, etc.)		Black, Whit Specify:	White
1	ed	15. Dec	edent's Educ	cation	16a.	Decedent's Us	ual Occup	ation			16b. Kin	d of Business	
	plet	(Specify only h	ighest grade	completed)		(Give kind of w life. DO NOT	ork done d use retired	during most)	of working	'			
	Completed	Elementary/Secondary (0-	12)	College (1-4or 5-	-)	Sewin	g Fac	ctory			We	bster'	S
1	e C	17. Father's Name (First, Mic								First, Middle,			
	To Be	George Wesly	Rinel	hart				Jan	e Reb	ecca M	nTTe	er	
1		19a. Informant's Name/Rela				Mailing Addres							
		Mary Alice S	Snyder,	/daughter		B East				æstmin			21157
1		20a. Method of Disposition 1 ØBurial 2 □ Crema	tion 3 □ B	emoval from State	20b. Place of cemeters	Disposition (Na y, crematory or	ime of other plac	e)	Dat	e	20c. Loc	ation - City or	Town, State
		'4 □Donation 5 □Oth		assiovas irosis State	Leiste	ers Chu	rch C	${ m em}$ 1	/05/2	2004	Wes	tminst	er, MD
DDCB.		21. Signature of Funeral Se	rvice License	96								., P.A.	
ž _		John Kx	Ll?	3								er, MD	21157
9		23a. Part1. Enter the diseas shock, or heart failure.	se, or complic List only on	cations that caused to be cause on each line	the death. Do n	ot enter the mo	de of dyin	g, such as o	cardiac or r	espiratory arr	est,		Approximate Interval Bett Onset and I
or l		Immediate Cause (Final disease or condition		PNE	UMOI	VIA							1 WEZ
al er		resulting in death)		Due to (or as a	consequence	of):				_			2
		Sequentially list conditions,	ь	CONC	SEST,	NE	468	1RT	TA	FILUR	-		3×
٦.	line	if any, leading to immediate cause. Enter Underlying	~		consequence	of):		~					1111
	kamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	る 。	ATR	IAL,	FIBR		4770					4/6
	Ĭ.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	ATR Due to (or as a	AC	or): F/BR or):	166.		N				34
	cal Ex	if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		ATR Due to (or as a	IAL,	or): F/BR or):	166.		N				4 16 3 4E
	edical Ex	IF FEMALE:	L _d	Due to (or as a	consequence of	or): F/BR or):	166.		N			3d Date of de	4 YE
	edical Ex	IF FEMALE: 23b. Was decedent pregnar in the past 12 mopths?	nt 2	ATR Due to (or as a	of pregnancy	or): F/BR or):	7 E	NY.	N			3d. Date of de Month	3 YE
	edical Ex	IF FEMALE: 23b. Was decedent pregnar	nt 2	Due to (or as a CORO 3c. If yes, outcome of 1 Live birth 2	of pregnancy	of): FIBR Of): A 3 Ectopic	7 E	NY.	N				•
	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnar in the past 12 mopths? 1 □ Yes 2 □ No	nt 23	Due to (or as a COCO 3c. If yes, outcome of 1 Live bith 2 4 Pregnant at t 9 Unknown	consequence of Consequence of pregnancy 2 Fetal death lime of death	## / B P /	oregnancy	r S	N	-ASE	23	Month	•
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** SHIRLEY T. SMITH **JANUARY** 15 2004 0600 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 29361 HAWKES HILL ROAD EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. OCT 24 1925 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1□M **X**□F MARYLAND 78 Yrs. Director 220-14-3821 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show Examiner must be notified at 1X Yes 2 No Directo TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29361 HAWKES HILL ROAD 21601 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 X Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATOR** 11 PUBLIC SCHOOL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNKNOWN PAULINE SMITH ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29361 HAWKES HILL ROAD, EASTON, MD 21601 DORIS M. THOMPSON/PER. REP. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 1-20-2004 EASTON, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licenses JOSA1 Cotrone 21. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) grade Neuroendocrine Carcinoma Physician a. H194 Zmonths /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 20nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 3 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural s after de-ral Director: Atr 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0051/32 1-15-24 ahreyo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 598 CYNWOOD DR. EASTON, MD 21601 JORGE H. ABREGO M.D. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** Month John Guilford Sherman 1426 /Medical January 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Chestertown
If Under 1 Year If Under 24 Hrs. Chester River Hospital Center 8. Date of Birth (Month, Day, Year) Nov. 28, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Days Hours Director 214-24-8858 1926 Maryland Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, It a Medical Examins at must be retilied at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TYes 2 □ No Md. Kent Chestertown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21248 Florida Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Types 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Postal service <u>Letter Carrier</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Edward Sherman 2 Mary Agnes Lippy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 fs nany injury or other traun 21248 Florida Avenue, Chestertown, Maryland 21620 of Disposition (Name of 20c. Location - City or Town, State Elsie Mae Sherman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel Cemetery 1/8/2004 Rock Hall, Maryland 21. Signature of Funeral Service License Fellows, Helfenbein & Newnam Funeral Home, 130 Speer Road Chestertown, Maryland 21620 Sup St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MUNA UIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, the attending physicien Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Dav Year 4 Pregnant at time of death signed by the al 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed certificate Division of Vital 1□ Yes 2 🖸 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No P 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident 6 Could not b 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The I 29 Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shanahan, Suite 2 - Chestertown, 120 Speer Kd M.D. 31. Date filed (Month, Day, Year) 32. Registrar Signature State 2004 9 8-04 JAN 0 Registrar

		For State Registrar		State of	Marylar		artmen rtificat					eg. No. CU	04	023	12
		1. Decedent's Name (First, Mi	ddle, Last,)							2. Date of Dea Month		Year	3. Time of D	
Physic /Med		James	Ric	hard	Scott	Jr.					January	10, 20	04	3:30	РМ
Exam		4a. Facility Name (If not institu	tion, give	street and num	ber)		4b. City,	Town, or	Location	of Death		4c. County of			
		321 South Car	non	Avenue					town			Washin			
Funera	1	5. Social Security Number	6. Se:		7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	Cou	olace (State or ntry)	Foreign
Directo		219-72-8075	<u>'</u> 'X]M 2□F	45	Yrs.					April 1	2, 1958	Mar	yland	
P .		Usual Residence of Decedent 10a. State 10b. Cou	ntv		10c. Ci	ty, Town or Lo	cation						Τ,	10d. Inside City	Limits
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36 is aft	by	1 Never Married 2√ N 3 Widowed 4 Divor		If Yes, Give	9		1 ☐ Yes	2 X No	Specify:			Specify:	Wh	nite	
21215-0036 sd within 72 hours after death with the Maryland gjene. arthen "nature!, or ftems 23a or 28e-f show , the Medical Examiner must be notified at	8		lent's Edu			16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of Bus	iness/In	dustry	
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should be filed and Mental Hygi marked other imatic svent, in matic svent, in	To B	James Richa	d Sc	ott Si	r.			1	M	abe1	E. Hair	nes			
Maryland ad 2 should be file lith and Mentai Hy 27 is marked oth	-	19a. Informant's Name/Relati	onship (Ty	rpe, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Number	City or Town, S	state, Zip	Code)	
Md 2 alth a 27 is 1		Medina Scott		7	wife	321 8	South	Canr	ion A	venu	e Hagers	stown, M	aryl	Land 21	740
Baltimore, Maryla permit. Pages 1 and 2 should Depertment of Health and Men Important: if Item 27 is marke say Injury or other treumatic.		20a. Method of Disposition			- 1 1	Place of Dispo cemetery, crei	sition (Nan	ne of ther plac	e)		Date	20c. Location - 0	City or To	own, State	
mo Page ento nt: if		1 ☐Burial 2 ☐ Cremati 1 ☐ Donation 5 ☐ Othe			State				1	1/15	/2004 H	lagersto	wn,	Maryla:	nd
alti		21. Signature of Funeral Serv				22	2. Name an	d Addres	s of Facili		innich I				
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ecords, P.O. Box 68760, iaw requires that the death certificate be execut as been signed by the attending physician and 2 should be detached for use as the burial-transport	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2		nth 2 ☐ Feta ant at time of o	al death 3[Ectopic pr					23d. Date Mon		ery Day Ye	ar .
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of Vita Physicien: this certific	2	1 ☐ Yes 2 ☑ No	ŀ	lospital: 1 ☐ Ir	npatient 2	ER/Outpatier	nt 3 DC	Othe Othe	er: 4 □ Nu	ursing Ho	me 5 Reside	nce 6 □Othe	(Specit	ý)	
Vision O' Attending Ph r death. ector: After th		Z LI Accident	stigation	28a. Date o (Month	t Injury h, Day Year)	28b. Time o Injury	f M	8c. Injury Work 1 □ '	vat ⟨? Yes 2□		28d. Describe ho	ow injury occurre	d		
Divisor To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the	Certification;		ald not be ermined	28e. Place buildin	of Injury - At h ng, etc. <i>(Speci</i>	nome, farm, st ify)	reet, factory	y, office			28f. Location (St City or Town	reet and Numbe n, State)	r or Aura	al Route Numbe	er,
he Hospi n 24 hour he Funer bletely fill	Medical				sis of examina						and due to the cared at the time, d				
To ti withi To ti	Σ	29b. Signature and title of cer	ifier					. License		2		9d. Date signed		-	
		1/1/4	/				1	200	502	002	-	01/12/	200	4	
JH-10		30. Name and address of per	ion who co	ompleted cause	e of death (Ite	m 23a) (Type,									
	tate trar	31. Date filed (Month, Day, You	ar)	32. B	egistrar's Sign	di A	perte	,		-	town mu				

			For State Registrar	State of Ma	aryland / [irtment of H tificate of L		d Mental H	ygiene Reg. No	ZUIII	+ 0231	3
E	Dhysiai	20	1. Decedent's Name (First, Middle, Last)		*				2. Date of I	Da		3. Time of Death	/
	Physici /Medic		George Monroe STO				45 Oit 7-11-1	Landing of D	Janu		10 200 County of Dec	4 7.100	М
	Examin	er	4a. Fecility Name (If not institution, give sawashington County				4b. City, Town, or Hagers		eatn		shingt		
.00	Funeral		5. Social Security Number 6. Sex		e (In yrs. last bii	thday)	If Under 1 Year	If Under 24	Hrs. 8. Date of E		9. Bi	rthplece (State or Forei	ign
	Director		219-34-5687	M 2□F	67	Yrs.	Months Days	Hours A	July	1, 19	36 1	Maryland	
	pu k		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limi	ts
	Aaryla f eho	ō	Maryland Washing	ton			stown					1 TyYes 2 □ N	10
	289-	Director	10e. Street and Number			501	10f. Zip Code			10g. Ci	lizen of What C	country?	_
	h with	a Di	819 Woodland Way				2174	12		US	SA		
	eme 2	Funerai	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S.	13. 1	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin' n, Mexican, P	? (Specify Yes or I uerto Rican, etc.)	Vo-	14. Race - Am Black, Wh		
36	or it	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ 1 If Yes, Give		1	I□Yes 2⊠No	Specify:			Specify:	white	
9	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28e-f ehow ta Medical Examinar maat be notified at	ed b	15. Decedent's Educ	Year or Dates		. Deced	lent's Usual Occupa	ation		16b. F	Kind of Busines	s/industry	
215	hin 72 n na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	i+)	(Give life. L	kind of work done of OO NOT use retired	during most of ()	working				
21	ed wit	Com	12)		pow	er contro					government	
Ind	i 2 should be filed within 72 hours after death with the Marylar h and Mental Hyglene. 7 ie marked other then "naturel", or iteme 23e or 28e-1 ehow rie marked other then "naturel", or iteme 23e or 28e-1 ehow raumatic event, the Medical Espainer must be notified at	Be	17. Father's Name (First, Middle, Last) unknown						n R. Sto		n Sumame)		
Z	d Mer narke	2	19a. Informant's Name/Relationship (Typ.	ne Print)	101	Mailin	g Address (Street a				or Town State	Zin Code)	
Ma	od 2 si Ith an 27 ie i traui		Jane G. Stone - w				Woodland						
Battimore, Maryland 21215-0036	s 1 ar f Hea item		20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of natory or other place		Date		ocation - City o		
Ë	Page nent o int: If iry or		1 ⊠ Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State		-	wn Mem. P	- 1	1/14/04	На	gerstov	vn, Marylan	ıd
alti	permit. Pages 1 and 2 should by Department of Health and Monta Important: If item 27 is marked any injury or other traumatic as 90.00.		21. Signature of Euroral Service License	nm.	1	1	. Name and Addres						
	80 = 9		Cott	111/0	mic		15 E.Wils				vn, Md.	1	
3			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause in each li	ne. //			A11				Approximate Interval Between On a to Coat	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulling in death)	SEVEN	E 1791	MX	1 CENC	=भागवा	UPACH	1		119104	
	Examiner			Due to (or as	a consequence	or):	TAEHU	CARDI	A			1/9/04	,
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence		(Mell)	Chirocht				11.77	
	cuted nd ransit	Examine	Cause (Disease or injury that initiated events										
30,	e exe cian a urial-1	EX	resulting in death) Last	Due to (or as	a consequence	of):							
8760,	death certificate be executed attending physician and of for use as the burial-transit	dical											
9 x	eath certific attending p	Physician/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy						23d. Date of d	elivery	
Вох	d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)			-	Month	Day Year	
ö	t the by th ache	hysi	9 Unknown	9□ Unknown									
S,		by P	Part II. Other significant conditions con	tributing to death b	ut not resulting	in the u	nderlying cause give	en in Part I.				to the cause of death?	
ord	v requires been sign should be	ted							_ 10	Yes 2	2 Q /No 3 □ F	Probably 4 Unknow	ΝΠ
Records,	S b	Completed							- 24a. Wi	as an topsy rformed?	24b. Were a prior to death?	autopsy findings availab completion of cause o	ole if
a	ate pa								1 ☐ Yes	2 2 √No		s 2 No	
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ent 2 ER/O	utnation	I 3□ DOA Oth	or.	Death (Check onling Home 5 ☐ Re		6 □Other /So	ecify)	
10	g Physe er this eral di	-	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of		y at	28d. Describ			ouily)	
ion	Attending r death. ector: After by the funer	atio	1 Natural 5 Pending investigation	(141011111, 04	y rour,	пцогу		Yes 2 □ No					
Division	f or Attencater death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, fa c. (Specify)	arm, str	eet, factory, office			n (Street a Town, Stat		Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Ce	29a. Certifier 1X Certifying Phys	ician: To the best	of my knowledge	o doati	a cooured at the tra	no data and n	lace, and due to th	20 021160/0	and manner	as stated	
	Hospitat 24 hours a Funeral I stely filled	edicai	(Check only 2 Medical Examir one)		f examination ar								
	To the within 2. To the complete	Me	29b. Signature and the of certifier)	Λ		29c. Licens	e number		29d. Da	ate signed (Mor	nth, Dey, Year)	_
			Mellet	/ FAMIL	4/14/51	CCPY	V D	1706)	1	w. 11,	2004	
	-54		C- 1	mpleted cause of	leath (Item 23a)	(Туре,	Print)	1.	- 11.			146	
Sp.			31. Date filed (Months Day, Year)	JUEN 1	ar's Signature	14)	/VUNTHE	m/fre	MA	COCAS	lown 1	M (V	
kļa:	Sta Regist	ate rar	JAN 1'3 20	04 Are	A.	19	nerse					2/7/2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2004 9, 4:00 Рм January Sours Reatrice 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington 212 Summit Ave. Apt. 1 Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
June 27, 1939 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days 1□M 20 F Maryland Yrs. 64 220-34-0720 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 □ No Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 212 Summit Ave. Apt. 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 💥 No Specify: White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hotel 10 Housekeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Virginia Barger Andrew Montgomery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21740 212 Summit Ave. Hagerstown, MD Steven A. Montgomery/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1/13/2004 Smithsburg, MD Smithsburg Crematory ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave. Rest Haven Funeral Chapel S. Mark Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4 MONTHS Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): GARE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death

4 Pregnant at time of death 23d Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHY SEMA 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

Completed by

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-1 show any injury or other treumatic event, ite Medical Exercises.

Examiner signed by the attending physician and d be detached for use as the burial-transi Physician/Medical Completed by tilled in by the funeral director, Certification; To Be

has

After

atter death

24 hours a

completely within 24 To the F To the

or Attending

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

5 Pending investigation

6 Could not be determined

performed? 1☐ Yes 2☐ No 26. Place of Death Check online

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

1-12-2004 CAMPUS RD MD 21742 who completed cause of death (Item 23a) (Type, Print) //// O

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Registrar

31. Date filed (Month, Day, Year) 1 2 2004

25. Was case referred to medical examiner?

29b. Signature and title procertifier

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide 4 \(\text{Homicide}

29a. Certifier

Medical

1 Natural

32. Riégistrar's Signature

101 T

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedents Name (First, Middle, Last) Harry William Shrader 2. Date of Death Month January **Physician** 12:35P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12435 Pleasant Valley Rd. Smithsburg Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 25, 1936 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**□ M 2□ F 214-34-2402 Yrs. 67 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ral', or items 23a or 28a-f show Examiner must be natified at Md. Washington Smithsburg 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12510 Pleasant Valley Rd. 21783 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced *natural ieted ar than "nature 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)

Machinist (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4or 5+) Door Co. 10 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked othe eny injury or other traumatic event, odgs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy A. Shrader Elizabeth A. Diffendafer 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10603 Will Rich Rd. Williamsport, Md. 21795 Betty L. Miner (sister in Law) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State ' 4 Donation 5 Other (Specify) Smithsburg Crematory Jan.9, 2004 Smithsburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21763 Runs 23a art1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YOCARDIAL INFARCTION **Physician** D MINUTE /Medical Due to (or as a consequence of). **Examiner** ARTERIOSCLEROTIC ARTERY DISEASE CORDNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 □Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 Tes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) Neighbor Yes 2 No 2 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Home Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 000435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RULL VERUE 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

	4,		1 - For State Registrar	State o	f Maryland /			of Healtl		lental Hy	giene 2	004	02316
}	Physic /Medi Exami	cal	1. Decedent's Name (First, Michael Lands) 4a. Facility Name (If not institute)	Sue			4b. City, To	Stantown, or Location	on of Death	2. Date of De Month	Day 13	Year 2004 ty of Death	3. Time of Death 2:12 PM
	Funeral Director		5. Social Security Number 212–54–8390 Usual Residence of Decedent	6. Sex 1 □ M 2 🙀 F	7. Age (In yrs. last bi		If Under 1	Year If Und Days Hour	der 24 Hrs.	8. Date of Bir Month, Da May 5,	1948	Cour	olace (State or Foreign ytry) yLand
	the Maryland 28e-f ehow	Director	10a. State 10b. Cour MD Garr 10e. Street and Number	•	10c. City, Tov Frien		lle	odo.			10a Cisi		0d. Inside City Limits 1 No 2 □ No
0036	d within 72 hours after death with the Maryland Jiena. rithen "netural", or Itama 23e or 28e-f ehow tre Medisul Exartirer must be notified at	by Funeral	721 Morris Ave 11. Marital Status 1 Never Married 2 M M 3 Widowed 4 Divorce	12. Was Dece Armed For arried 1Yes	2 (XNo e		10f. Zip Constant of the second of the secon	21 of Hispanic Cuban, Mexi		ecify Yes or No Rican, etc.)	- 14. Ra	USA ace - Americ ack, White,	an Indian,
Maryland 21215-0036	be filed within 72 tal Hygiens. d other then "na!	Be Completed		e, Last)	-4or 5+)	(Give kir	NOT use i	done during m retired)	ther's Name	(First, Middle,	Maiden Suma	n Home	,
	ges 1 and 2 should be it of Health and Mental If item 27 is marked or or other treumatic ev	To	19a. Informant's Name/Relation Dennis L. Stan	nship (Type, Print)	19t	o. Mailing . '21 Mo	Address (S	treet and Nun	nber or Rura	Loude N Route Number 222,	er, City or Town	n, State, Zip SVILLE	Code) e, MD 2153
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any njury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service	(Specify)		nger	cemet	ery, J	an 16	, 2004 es, P.A.		nger,	MD
	Physician and business the burial-transit	ical Examiner	23a. Part1. Enter me dispase, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	or as a consequence	of):	the mode o	f dying, such	as cardiac o	ntsvill	rest,	ان ب	Approximate Interval Between Onset and Death RE HOLU CUTTERN NOUT
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bir	ome of pregnancy th 2 Fetal death int at time of death wn		topic pregr					ate of deliver onth	y Day Year
ords, P	w requires that been signed b should be deta	ρ	Part II. Other significant condi	0 .)	ath but not resulting in	n the unde	orlying caus	e given in Par	t I.		es 2 No	tribute to the	e cause of death?
ital Rec		Be Completed	25. Was case referred to medic	al				26. Pla	ce of Death	24a. Was autop perfor 1 Yes	sy med? 2 No	prior to com death?	sy findings available pletion of cause of
Division of Vital Records,	ding Phy h. After this funeral o	P		28a. Date of (Month tigation	patient 2 ER/Ou Injury , Day Year) 28b. 1	itpatient Fime of njury		Other: 4 🗆 I Injury at Work? 1 🗆 Yes 2 [2	ne 5 □ Resid 8d. Describe h			
DIVIS	To the Hospital or Attanwithin 24 hours after deatl To the Funaral Director:	al Certification:	29a. Certifier 1 Certify	ing Physician: To the b	of Injury - At home, fa g, etc. (Specify) pest of my knowledge	, death oc	curred at th	ne time, date :	and place, a	City or Tow	n, State)	annor an ain	Route Number,
	To the Ho within 24 h To the Fui completely	Medical	(Check only 2 Medical	and manne	sis of examination an	d/or invest	29c. Lic	my opinion, decense number	eath occurre	d at the time, o	late and place,	and due to t	ay, Year)
	Sta Registr		. 151 11	OHARS han 32. Rev	1 .	Type, Prin	nt)	North		olfe S	treet F	Baltim	21287 21287 Noryland

			For State Registrar	State of M		epartment of I			giene Reg. No. 2	304 (1231
10	Blausia	w w	1. Decedent's Name (First, Middle	, Last)				2. Date of De	nath Day	year 3. T	ime of Death
	Physici /Medi		John	Wesley	Stotle	<u> </u>	Sr.	Janu		2004	1800 PM
	Examir	ner	4a. Fecility Name (If not institution	1 1	\ a. \	4b. City, Town, o	or Location of Deat	h - 0/	4. County	of Death	
			5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birth	day) If Under 1 Year	1 Dev 10	8 Date of Bir	<u> </u>	9. Birthplace (S) U
4"	Funeral Director		213-22-2877	1 N M 2 □ F		rs. Months Days			". 1930	MD	state or Foreign
	p ,		Usual Residence of Decedent		40- Oit T						
	ehov	5	MD 10b. County	gany	10c. City, Town	or Location Imberland					ide City Limits Yes 2 □ No
	ith the Marylar or 28e-f ehow	ect	10e, Street and Number	, ,		10f. Zip Code			10g. Citizen of V		
	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show Jical Executed the profited at	Funeral Director	12 N. Johnson	Street		101. 215 0000	21502		-	SA	
	after death w or Items 23s	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No	- 14. Rac	e - American Ind	ian,
36	or Ite	y Fu	1 Never Married 2 Marri	ed 1 Yes 2 1		1 ☐ Yes 2 ☐ No	Specify:	o Hican, etc.)		ck, White, etc.	
21215-0036	72 hours naturel', alcal Exe	d by	3 ☐ Widowed 4 ★ Divorced	Year or Dates:						white	
5	in 72	Completed	15. Decedent (Specify only highes	t grade completed)	(Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of wor	rking	16b. Kind of B	usiness/Industry	
212	e filed within Il Hygiene. other than	E O	Elementary/Secondary (0-12)	College (1-4or 5)+)	sident	-/		Matting	y & Stotl	er
	be filed ital Hyg id otherwent,	Be C	17. Father's Name (First, Middle, I	· ·			18. Mother's Nar			10)	
ylaı	should be ind Mental marked o	To	John Wesley	Stotler, Sr.				B. Card S			
, Maryland	nd 2 s lith ar 27 ie r trau		19a. Informant's Name/Relationsh John Stotler Jr.	nip (Type, Print) SON	19b. I	Mailing Address (Street 218 Cedar A	Ave Unit A	Gran	d Forks	State Zip Gode) AFB ND	58204
Baltimore,	90= 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Place of I cemetery Scarpell	Disposition (Name of crematory or other plain Funeral Home	e, PA	Date 1/17/2004		City or Town, Sta	MD
Balti	permit. Page Department Importent: eny injury once.		21. Signature of Funeral Service I		111	22. Name Sand Addres			rland MD	24502	
			23a. Part1. Enter the disease, or	complications that caused	I the death. Do no		ginia Avenu ng, such as cardiad			Appro	ximate
	Physician		Immediate Cause (Final	only one cause on each lin	ne.	1		,,		Interv	al Between and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of	Jure .				10	days
	Examiner		Convention he lies conditions	, Hype	rtensi	on Em	ergeno			10	daus
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequence of):				110747	, and
	ecute and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Vieto	LOOLC	tncer.	phalo	path	4	10.0	lous
8760,	ate be executed hysician and the burial-transit	cal E	,	Due to (or as	a consequence of			f.	J)
687	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit			d		weel		-5556			
Box (eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d Dat	e of delivery	= =====================================
-	death e atte	cla	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at	2 Fetal death time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	y		Mo		Year
P.0	at the de by the a	hys	9 Unknown	9□ Unknown							
	res that igned to be det	by	Part II. Other significant conditio	ns contributing to death bi	ut not resulting in t	he underlying cause giv	en in Part I.			ribute to the caus	
Records,	w requir been s should	Completed	Muripe o	Trokes, L	LOCODO	lry HYT	ery	101	′es 2□No	3 Probably	4 Unknown
ec €	e law has b	ag l	DISPUSE, A	nemia, s	eizur	2S,		24a. Was autop	sy p	Vere autopsy find prior to completion	lings available of cause of
a	n: The licate har, page		Artial Fibr	illation)					leath?)
Ζ	sicien: "1 certifical irector, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		oth	26. Place of Dea	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			_
o	Phys or this oral di	 	27. Manner of Death	28a. Date of Injur (Month, Day		ne of 28c. Injur	4 □ Nursing H	ome 5 Resid	lence 6 Other		
ion	Attending Fir death. ctor: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investig	,	/ Year) Inji	ıry ı Wor	k? Yes 2 □No		. ,		
Division of Vital	i Pitte	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At home, farm c. (Specify)	, street, factory, office		28f. Location (S City or Tox	Street and Numbern, State)	er or Rural Route	Number,
	Hospite 14 hours Funerel 1ety filler	Medical C	29a. Certifier 1 Certifying (Check only one)	g Physician: To the best of exeminer: On the basis of and manner sta	examination and/	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occur	, and due to the o	cause(s) and ma date and place, a	nner as stated. and due to the car	use(s)
	ro the	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed	(Month, Day, Ye	ar)
	->-0		>	4. Cholan		D58	8853		1/13	3/04	-
	12		30. Name and address of person v	who completed cause of de	eath (Item 23a) (T	/pe, Print)				1 1	
	10		Habib Cho	tani mD	PO	BOX265	G	rants	ville.	MDa	1536
	Sta Registr	7	31. Date filed (Month, Day, Year)	732. Registra	s's Signature	don't a	4 .		, , , , , , , , , , , , , , , , , , ,	-	

1. Decedent's Name (First, Middle, Last)

Hazel D. Tidwell

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

			Long V	iew Nurs	sing Home	<u> </u>				Manc	hester			Carr	oll	
	Funeral		5. Social Security	Number	6. Sex	7. Age (In yi	rs. last birthda	y) If Und Months	er 1 Year Days		Hrs. 8. Date Min. (Mor	of Birth	1913	9. Birth	place (State or Fo ntry) Cyland	reig
	Director		214-01-9	9084	1□M 2∏F	90	Yrs.	121011111	00,0	110070	Jun	187	1913	Mai	rýland	
	0		Usual Residence	_										1		
	rylar how		10a. State	10b. County	40 E	10c. 0	City, Town or I	Location							10d. Inside City Li	
	Ma P-f s	Director	Maryland	Car	roll				M	anchest	ter				1 ☐ Yes 2——] No
	h the	ire	10e. Street and No	ımber				10f. Z	ip Code			100	g. Citizen of V	What Cou	ntry?	
	h wit	al	4555 W	entz Roa	ad					21102			U	JSA		
	deat deat	Funeral	11. Marital Status		12. Was Dec	cedent Ever in	U,S. 13	. Was Dec	edent of H	fispanic Origin	n? (Specify Yes Puerto Rican, e	or No-	14. Rac	e - Ameri ck, White,	can Indian,	
0	after or Ite		1 ☐ Never Mar	ried 2 Marri	ed 1 Tes	2 R-No				Specify:	derto Moari, e	,			hite	
02	ours	b	3 🔀 Widowed	4 ☐ Divorced	Year or I	Dates:		1 103	202110	оресну.			Specify	/: VV :	111 00	
Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show with injury or other traumatic event, the Modical Examiner must be notified at once.	Completed	(Sne	15. Decedent	's Education t grade completed	1)	16a. Dec	edent's Us	ual Occup	ation	f working	16	b. Kind of Bu	usiness/In	ndustry	
2	Be .	Jple	Elementary/Sec			(1-4or 5+)	life.			during most of d)	· wonding		mo á	Lowi	na Compa	n
21	od wi	ő		9				Ta:	lor				Tal	TOLT	ng Compai	.1)
pu	othe vent	Be (17. Father's Name	(First, Middle, I	Last)						Name (First, I		iden Surnam	10)		
<u>a</u>	uld b Aenta rked tice	일	Willia	em F. Do	wling					Cat	herine	Ogle				
ar)	sho man uma		19a. Informant's N	lame/Relationsh	nip (Type, Print)		19b. Mai	iling Addre	ss (Street	and Number	or Rural Route	Number, (City or Town,	State, Zij	o Code)	
Σ	alth a		Edward	R. Coll	pert, son	ì	45	55 We	ntz E	Road, M	ianchest	er,	MD 211	L02		
Baltimore,	f Heg f Heg tem othe		20a. Method of Dis	sposition		20b	. Place of Disp cemetery, cr	position (N	ame of	re)	01 ^{Date}	20	c. Location -	City or To	own, State	
20	age ant of t: If i			Cremation 5 □ Other (Sp	3 □Removal from	State	orelan				2004		Balti	more	, MD	
₹	rten rten njur		21. Signature of F			10072				ss of Facility					•	_
Ba	Depa impo eny i		21. Signature of t	Ziorai dei vice i) 1/5					-			eral H		074	
			XI	wu		1	up				St, Ha			ע אַב		
			23a. Part1. Enter shock, or he	the disease, or art failure. List	complications that only one cause on	caused the de each line.	eath. Do not e	nter the mo	de of dyir	ng, such as ca	rdiac or respira	tory arres	t,		Approximate Interval Between	ı
1	Physician					105				٢					Onset and Death	1
4	/Medical		Immediate Cause disease or conditi			ACT	ء جيسي	_	كربن	+c-	-				· I · en s	
	Examiner		resulting in death)		a	Due to	(or as a cons	equence of):						7	
		je						•	,						,	
	es that the death certificate be executed igned by the attending physician and be detached for use as the bural-transit	Examiner	Sequentially list o	onditions	b . ———	Due to	(or as a conse	equence of):					-		_
Ċ,	exec in an rial-tr	E	Sequentially list of any, leading to i cause. Enter Und Cause (Disease of	mmediate erlying			(,-							
Box 68760,	e be rsicia e bul	cal	that initiated even	15	c	Due to	(or as a conse	nuence of						-		_
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J.	the d y the iched	ys	Part II. Other sign	incani conditio	ns contributing to t	ieath but not n	esulling in the	undenying	cause giv	en mranti.	230				bably 4 ☐ Unkr	
	that ed b deta	<u> </u>										1 LI Yes	21-NO	3 Pro	Dabiy 4 ⊔ Unkr	IOV
ds,	requires that the been signed by th thould be detache	d b									24a	. Was an a	autonev	24b. W	ere autopsy findin	as
Ö	v requ been shoul											performe		av	ailable prior to empletion of cause	-
Division of Vital Recor		ğ												of	death?	
=	The ate h	Complete									140	1 J Yes	2. No	11	LYGS 2LINO	
ıta	ien: artific ctor,	Be	25. Was case refe examiner?	rred to medical							Death (Check	oniv one)		1000		
_	ysic lis ce dire	၉	1 ☐ Yes 2 Ē	No	Hospital: 1 □	Inpatient 2	☐ ER/Outpation	ent 3□ C	OA Oth	ier:	ng Home 5□	Residenc	e 6 □Othe	er (Specit	(y)	
0	g Ph erth neral		27. Manner of Dea	th 5 ☐ Pending	28a. Date	of Injury onth, Day Year)	28b. Time Injury		28c. Injur Wor	y at k?	28d. Des	cribe how	injury occurr	ed		
<u> </u>	ath. r:Aff	atic	2 ☐ Accident	investig		,,		М		Yes 2 ☐ No						
3	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ned 286, Plac	e of Injury - At	home, farm, s	street, facto	ry, office		28f. Loca	tion (Stree	et and Numb	er or Rura	al Route Number,	
5	affe Direction	Ě	4 D Homicide		Build	aling, etc. (Spe	City)				Ony	0, 10,111,	Jiaie)			
	spita nours nerei		29a. Certifier	1□ Certifying	Physician: To the	e best of my ki	nowledge, dea	ath occurre	at the tir	ne, date and p	lace, and due t	o the caus	se(s) and ma	nner as s	tated.	
	24 h	edical	(Check only one)	2 Medical E	xaminer: On the t and mai	oasis of exami nner stated.	nation and/or i	investigatio	n, in my o	pinion, death	occurred at the	time, date	and place, a	and due to	o the cause(s)	
	oth ithin oth omp	Me	29b. Signature and	d title of cartifier				25	c. Licens	e number		29d	. Date sign	d (Month,	Day, Year)	
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		313	Of Date Date (14)	Steries	No Also	Conjunction Sim		e rev	4 \ 12	- 4-10	w you				ţ	
	Sta		31. Date filed (Mo	ntri, Day, Year)	201	Registrar's Sig			•		3					
	Registi	rar		JAN 1	3 2004	Alleneur.	15.	600	w							_
DH	MH 16 Rev 6/9	5														

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death Month

4b. City, Town, or Location of Death

January

11, 2004

4c. County of Death

8:05 pm

CATHERINE MARIA TILEY
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar 1. Decedent's Nam	ne (First, Middle, Las	(t)	Ce	rtificate of	Death	2. Date of D			0 2 3 1 (
Physici /Medi		Cathe		ria Tiley				Janua	ry 3 :	200 ^{¥eer}	2:00 P M
Examir			If not institution, give 1 Hospita	street and number) 1 Center		4b. City, Town, o Westmin		Death		ounty of Death	
Funeral Director		5. Social Security N 217-60-3	609 1	ex □ M 2 (X) F 7. Age (In	yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days		Min. (Month, L	Sirth (Day, Year) 9,1951	Cour	place (State or Foreign try) yland
No to		Usual Residence of 10a. State	10b. County	100	c. City, Town or Lo	cation			·	1	Od. Inside City Limits
a-fah	ctor	MD	Carrol	1	New Wir	dsor					1 ☐ Yes 2 💢 No
or 28	Director	10e. Street and Nu		- I D.I		10f. Zip Code	,			of What Cour	ntry?
18 23s	Funeral	1414 U	ld New Wi	12. Was Decedent Ever	in II S 13 1	2177		1? (Specify Yes or N	1	S.A. Race - Americ	an Indian
portion: Tages I and Sandard Bright and Medical Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 2006.	by Fun		ried 2X Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Cub	an, Mexican, F	Puerto Rican, etc.)		Black, White,	etc.
atura	ted t		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation			of Business/In-	
Med .	Completed	Elementary/Seco	cify only highest gra- ondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire					
Hygier ther th			(First, Middle, Last)	Z	hist	ology te		Name (First, Middi		spital	
ked o	To Be		ingwald S	chultz				garet Desc		manie)	
and M s mar	-	19a. Informant's N	ame/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number of	or Rural Route Num	ber, City or To	own, State, Zip	Code)
ealth an 27 i			Tiley -				Windsor	Rd., Nev	v Winds	sor, Md	. 21776
If iter	=	20a. Method of Dis 1 Burial 2	position Cremation 3 🗆		Ob. Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Locat	ion - City or To	wn, State
rtmen rtant: njury		° 4 □Donation	5 Other (Specify) A	11 Count					esville	
Depa Impo any ir		21. Signature of Fr	Meral Service Licen Occure	" Wer Dle	/	Name and Addre		Hartzler New Wind:			
- 194		23a. Part1. Enter t	the disease, or comp	olications that cale the one cause on each line.						21//	Approximate
Medical sician and parial-transit	cal Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	ertying injury s	b. Due to (or as a cor Due to (or as a cor	nsequence of):	y fa	ilur	encer			
ite has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 [9 □ Unknown	month's?	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	y	555015	23d.	Date of delive	ry Day Year
been signed by should be detac	by	Part II. Other signi	ficant conditions co	entributing to death but not	t resulting in the ur	nderlying cause giv	en in Part I.		tobacco use		e cause of death?
	Completed							24a. Wa: auto perf 1 Yes	s an 2- posy ormed?	prior to con death?	osy findings available npletion of cause of 2 No
is certificate director, pag	Be	25. Was case refer examiner?		Nooritali /		-		Death (Check only	one)		
w 5	. To	1 ☐ Yes 2 ☑ 27. May er of Deat	NO	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of		4 U Nursii	ng Home 5 ☐ Res 28d. Describe)
r death. ector: Alter this certific by the funeral director.	tion	1 Natural 2 Accident	5 Pending investigation	(Month, Day Yea	r) Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □ No		now injury oc	curred	
after dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - Abuilding, etc. (Sp.	At home, farm, streecity)	eet, factory, office		28f. Location City or To	(Street and No own, State)	umber or Rura	Route Number,
ours Pera fille	edical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	rsician: To be best of my iner: On the basis of exam and/mar/ner stated.	knowledge, death nination and/or inv	occurred at the tirestigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time	cause(s) and , date and pla	i manner as sta ce, and due to	ated. the cause(s)
a Fur letely	Me	29b. Signature and	title of certifier	1/		29c. Licens			29d. Date sig	gned (Month, L	Day, Year)
within 24 hours after death. To the Funeral Director: Alter thi completely filled in by the funeral	-	, //11	Ι //	1 /							
	-	> ()	Mm	nl		01	547	2	1/6,	1200	4
within 24 h		30. Name and addr	ess of person who c	ompleted cause of death	(Item 23a) (Type, I	D1	547	2	1/6,	1200	f MD 21117

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Physician Day 14 2004 JANUARY 5:23AM JOYCE ANN TOWNSEND /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner CAROLINE DENTON RUXTON HEALTH OF DENTON | If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCH | 1. 1939 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months 1□M 2XF Yrs. Director 64 MARYLAND 216-40-3908 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No Funeral Director TALBOT CORDOVA MD 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA 31381 DUKES BRIDGE RD 21625 filad within 72 hours aftar death 12. Was Decedent Evar in U,S. Armed Forcas? Was Decadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 📉 No If Yas, Giva Yaar or Datas: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Š Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 10 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be i and Mantal h Pagas 1 and 2 should be OTIS FAULKNER ANNA BROOKS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dapartmant of Haalth Important: If Itam 27 I W. DWIGHT TOWNSEND/HUSBAND 31381 DUKES BRIDGE RD., CORDOVA, MD 21625 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 5 1 N Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) WOODLAWN MEMORIAL PARK 1-19-2004 EASTON, MARYLAND 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA CPSR 4 JOS44 Struck 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock or heart failure. List only one causa on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition rasulting in death) 2 YRS Examiner Due to (or as a consequence of) Physician/Medical Examiner Attending Physicien: The law raquires that the death cartificate be executed for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceusa of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No ata has baan signed paga 2 should be da Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy parformed? completion of cause of death? NO cartificata 1 ☐ Yes 2 ☐ No : Aftar this cartifical a funaral diractor, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Othar: 4 Jursing Homa 5 Residence 6 Othar (Specify) **≥**€ No edicai Certification: To 1 Yes 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of ath 1 Natural 2 Accident 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurrad s after dan. 5 ☐ Panding invastigation 1 Yas 2 No 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicida ò To the Hospital o within 24 hours af To the Funerel Di compiataly filiad is 12 Certifying Physician: To the best of my knowladga, death occurred at the time, data and place, and dua to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar statad. 29a. Cartifier (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signad (Month, Day, Year) mO 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Bagistrar's Signature State Registrar

	For State TCHD, 01/13/04, sbb 1. Decedent's Name (First, Middle, Last)	0611	tificate of Deat	2. Da	Reg. te of Death		3. Time of Death
ician	ROSE MARIE TRISTRAM				onth IUARY	8 2004	
dical miner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location			4c. County of Dea	
111101	6141 OLD TRAPPE RD.		TRAPPE			TALBO	T
	1□ M 2X F	vrs. last birthday) _	Months Days Hour	der 24 Hrs. 8. Da	te of Birth onth, Day Ye 3 193	ar) 9. Bi	rthplace (State or Foreig Country) MARYLAND
	218-24-4246 /	3 Yrs.		00.1		0	TAKTEAND
		City, Town or Loc	ation				10d. Inside City Limits
ctor	MD TALBOT	OXFO	RD				1 X Yes 2 □ N
Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What C	Country?
	92 S. MORRIS STREET 11 Marital Status 12. Was Decedent Ever in	n II S 13 VA	21654 Vas Decedent of Hispanic	Origin? (Specify Y	as or No-	USA 14. Race - Arr	nerican Indian.
Funeral	Armed Forces?	If	Yes, specify Cuban, Mex	ican, Puerto Rican,	etc.)	Black, Wh	
þ	1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates:	1	☐ Yes X☐ No Spec	eify:		Specify: V	HITE
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupation kind of work done during n DO NOT use retired)	nost of working	16b	. Kind of Busines	s/Industry
πple	Elementary/Secondary (0-12) College (1-4or 5+)					RESTAURA	Niti
	12 0	WA	AITRESS 18. M	other's Name (First	. Middle, Mais		M.Y.
o Be	RALPH RETALLACK			CY K. MCV			
Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street and Nu	mber or Rural Rou	e Number, Ci	ty or Town, State,	Zip Code)
	ALAN G. TRISTRAM/SON	1554	FORREST AV	E., DOVE	R, DE 1	9904	
	20a. Method of Disposition 20	b. Place of Dispos	sition (Name of natory or other place)	Date	200	. Location - City of	r Town, State
	1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Section)	HESAPEAKE	CREMATION	CTR. 1-10	-2004	STEVENS	SVILLE, MD
	21. Signature of Funeral Service Licensee Soseph m. Osthowski C. f. S.	P. FEI	Name and Address of Fa LLOWS, HELFE D.S. HARRISO	NBEIN & I	NEWNAM	FUNERAL 21601	HOME PA
	23a. Part1. Enter the disease, or complications that caused the canock, or heart failure. List only one cause on each line.		or the mode of dying, such	as cardiac or resp	ratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition		all lu				Onset and Death
	resulting in death) Due to (or as a con	sequence of):		NJ DING			1
_	Sequentially list conditions b.		U				
Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	isequence oi).					
xan	that initiated events resulting in death) Last C. Due to (or as a con	sequence of):					
a	d						
led						1	
Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of prediction in the prediction of the pre		Ectopic pregnancy			23d. Date of d	elivery Day Year
sicla	in the past 12 months? 1 ☐ Yes 2 ☑ No 9☐ Unknown	of death 5	Other (specify)			Month	Day 19a1
Phy	9 Unknown Part II. Other significant conditions contributing to death but not	t resulting in the un	aderhina cause awen in P	art I 2	3e Did tobac	co use contribute	to the cause of death?
ð	Part II. Other significant containers contributing to doubt but not	trosuming ar the di	idonying oddoo giron iir	uit i.	1 ☐ Yes		robably 4 DUnknow
Completed					4a. Was an	24h Wara	autopsy findings availab
gu					autopsy performed	prior to	completion of cause of
င္ပ	25. Was case referred to medical		26 P	lace of Death (Che	Yes 2	No 1 L Ye	es 2ENo
To Be	examiner?	2 ER/Outpatient	Other	Nursing Home		Siste	S-S-
	27. Mannur I Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury at Work?	28d. D	escribe how	njury occurred	NET IC
atlo	2 Accident investigation		M 1 ☐ Yes 2	2 🗆 No			
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury : building, etc. (Sp.		eet, factory, office	28f. L	ocation (Stree ity or Town, S	t and Number or i tate)	Rural Route Number,
	20 Outiling the last of the la	. Is a suited as a death	and the time and the			-/-) and	an stated
Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my (Check only one) 2 ☐ Medical Examiner: On the basis of examiner and manner stated.						
_	29b. Signature and title of certifier	7/	29c. License numb	per	29d.	Date signed (Mo.	nth, Day, Year)
Me		Las mi	D 7/	466		1/5/10	
Me	a rules / // / a a						
Me	30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	00	/	/ // /	

			For State Registrar	State of Maryland	d / Depa	artment of tificate of	Health a f Death	nd Mental H	ygiene Reg. No	2004	02322
			1. Decedent's Name (First, Middle, Last)					2. Date of 0	eath		3. Time of Death
	Physici		Elizabeth	Thuman Tayl	or			Jan.	9,	2004 Year	8 P. M
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town,	, or Location of			. County of Death	J
н			Vindabona Nursi	ing Home		Brado	lock H	gts.		Frederi	ick
	Funeral		Social Security Number 6. Second Security Number 6. Second Security Number 6. Second Second Second Security Number 6. Second Secon	7. Age (In yrs. la	ast birthday)	If Under 1 Yea	r If Under 2	4 Hrs. 8. Date of E	lirth		lace (State or Foreign
	Director		231-68-5126	M 254 83	Yrs.	Months Day	s Hours	Min. Dec.	7ay,4 6ai)	1920	"MD
	P .		Usual Residence of Decedent								
	aryla shov	_	10a. State 10b. County		, Town or Lo					1	Od. Inside City Limits
	8e-f	cto	MD Frederi	ick	Frede	erick			,		1XTYes 2 □ No
	ith th	by Funeral Director	10e. Street and Number	_		10f. Zip Code				tizen of What Coun	try?
	ath w	ra La	990 Waterford		-	1	21702		l	USA	
	er de	nue		 Was Decedent Ever in U.S Armed Forces? 	3. \ 13. \	Was Decedent of f Yes, specify Cu	f Hispanic Origi ıban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	lo-	 Race - Americ Black, White, 	
36	ori	Ϋ́F	1 ☐ Never Married 2 ☐ Married 33€34Vidowed 4 ☐ Divorced	1 ☐ Yes ②☐X No If Yes, Give	-	I∐Yes 2. XN	o Specify:			Specify: Wi	nite
8	hour tural	D D		Year or Dates:	16a Dagge	lant's Haust Oss	unntion		105 1		
ن	n 72	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	lent's Usual Occi kind of work don DO NOT use retii	e during most o	of working	10D. K	(ind of Business/Inc	lustry
7	thar.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		homema				own hom	ne
დ დ	filed Hygi Sther		17. Father's Name (First, Middle, Last)			11011101110		s Name (First, Middl	e, Maider		
au	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28e-f show imatic event, Ita Madicul Evanting must be notified at	To Be	Francis Thu	ıman				izabeth			
Maryland 21215-0036	Shoul Mari	1	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	a Address (Stree	et and Number	or Rural Route Num	ber. City o	or Town. State. Zip	Code)
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturat", or items 23a or 28e-f show any injury or other treumatic event, the Mudical Examinat must be notified at ODGs.		Nancy T. Kropet	tz (Daughter							
<u>ව</u>	r Hearlitern	1	20a. Method of Disposition	20b. Pla	ace of Dispo:	sition (Name of natory or other pl	()	Date	20c. L	ocation - City or To	wn, State
ဋ	age: ent of ent of or: If i		1 ☐ Burial X☐ Cremation 2 ☐ R `4 ☐ Dopation 5 ☐ Other (Specity)					y 1/11/0	4 Sr	nithsbur	o. MD
Baltimore,	artm orter injur	1 1	21. Signature of Funeral en ce Lice			_		-	-		
ã	Ped ming		Truck y 11	100AD	4	Jonard 31 E. N	Main S	ompson F t., Midd	let	raı Home own. MD	21769
			23a. Part 1. Enter the disease, or compli	ications that caused the death.						5 WII, 11D	Approximate
			shock, or heart failure. List only or Immediate Cause (Final		,		/ /			ır.	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequence new onset	cular	acuo	lent				econes
	Examiner			nous or Sel	L at	and Ch	· llab	en.		1	daus
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ence of):	100 715	riciari				angs
	uted d ansit	E I	cause. Enter Underlying Cause (Disease of injury that initiated events							4	
<u> </u>	n an	Examiner	resulting in death) Last	Due to (or as a consequence	ence of):						
760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cai		J							
89	tificat g ph) as th									10.0	
Вох	death certifica attending ph d for use as t	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetel (C-+:-				23d. Date of deliver	у
	deat e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea		Ectopic pregnan Other (specify)	су			Month	Day Year
o.	tt the by th tache	Physician/Med	9 Unknown	9□ Unknown							
'n.	uires that the de: signed by the a Id be detached f	by F	Part II. Other significant conditions con			derlying cause g	iven in Part I.	23e. Did	tobacco u	use contribute to the	e cause of death?
2	w require been si	ed	Influenza, ci	ronic obstr	uctive	pulmon	ory	1 🗆	Yes 2	□No 3 Proba	ibly 4 🗆 Unknown
Records,	aw re	Completed	disease den	entra				24a. Wa		24b. Were autop	sy findings available
Ě	The ite has	E							ormed?	death?	
ita	ian: rtifica stor, 1	Bec	25. Was case referred to medical				26. Place o	f Death Check on			
>	nysic nis ce dire	T0.	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3 □ DOA O	ther: 4 P Nurs	ing Home 5 ☐ Res	idence	6 □Other (Specify,	
0	ng Pt ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ury at ork?	28d. Describe	how injur	y occurred	
Ö	uttendir death. ctor: Al y the fu	atic	2 Accident investigation				∃Yes 2 ⊟No				
Division of Vital	l or Attending Physician: The lavallet deallet deallet deallet. Director: After this certificate has I in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office	9	28f. Location City or To	(Street an	d Number or Rural	Route Number,
	itelo rs aft rai Di										
	dosp t hou unel	cal	(Check only 2 ☐ Madical Examin	sician: To the best of my knowner: On the basis of examination	rledge, death	occurred at the	time, date and	place, and due to the occurred at the time	cause(s)	and manner as sta	ited.
	To the Hospitel or Attending Physician: within 24 hours atter death: To the Funeral Director: After this certificat completely filled in by the funeral director;	Medical	one)	and manner stated.				1			
	M	-	29b. Signature and title of certifier	Q		29c. Licer	nse number		290. Dat	te signed (Month, E	ay, Year)
	1		Kathleen W	skin M			13207	3	1/	14/04	
			30. Name and address of person who co	mpleted cause of death (Item:	1.7		D	A	, , , ,	0171	,
			Katyleen W. Ste	n m 610	Nin	th ave	1 RU	inswick,	Ma	. 2171	6
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 1 4	32. Registrar's Signatu		5 1	bout.				

			1 - For State Registrar	State of Marylar	nd / Depa		ealth and N	•	ne 200	4 02323
	Physici /Medic		Decedent's Name (First, Middle, Last) Clarice A.	Thomas				2. Date of Death Month January	Day Year 12, 2004	3. Time of Death 12:12 P M
	Examir Funeral Director	ier	4a. Fecility Name (If not institution, give s Chestertown Nursi 5. Social Security Number 216-10-2016	ng & Rehab. (last birthday)	Cheste	Location of Death CTOWN If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 24.		
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23s or 28s-f show any injury or other traumatic event, Its Medical Evaluant must be notified at any once.	al Director	Usuel Residence of Decedent 10a. State 10b. County MD. Kent 10e. Street and Number 5834 S. Hawthorne		ty, Town or Lo		31		Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
9003	hours after deet ural', or Itama 2	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 17 No If Yes, Give A Year or Dates:		Was Decedent of Hi I Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:		14. Race - Am Black, Whi Specify:	ne, etc. Nhite
Maryland 21215-0036	filed within 72 Hygiene. Hygiene. Ither than "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 11th	cation o completed) College (1-4or 5+)	16a. Deced (Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired, Homemake	furing most of work	ing	OWN Home	Mndustry
Marylan	d 2 should be th and Mental 17 is markad o traumatic eve	To Be	Clarence Akers 19a. Informant's Name/Relationship (Type Joanne Simns Range				Pearl S	tevens al Route Number, Ci	ty or Town, State,	
Baltimore,	it. Pages 1 and utment of Health trant: If Itam 27 njury or other tr		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Ri 4 ☐Donation 5 ☐Other (Specify) 21. Signature of Funeral Service License	emoval from State	Place of Disposemetery, cremetery, ${ m cremetery}$	sition (Name of natory or other place	etery 1		. Location - City or	Town, State Marylan
Ba	permit. Departr Imports any inji		23a. Part1. Enter the disease, or complications, or heart lailure. List only on	cations that caused the dear	13	llows, He O Speer R	lfenbein oad Ches	& Newnam tertown, N or respiratory arrest,	Funeral Maryland	Home, P.A. 21620 Approximate Interval Between Onset and Death
760,	Physician /Medical Examiner pe panial-transil	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec Chronic L Due to (or as a consec Chronic Co Due to (or as a consec Due to (or as a consec	lTI uence of): lo Vesic	cular fis	stula f	om 199	7	10 days
O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Vital Records, P.O. Box	w requires that is been signed by should be deta	ted by Ph	Part II. Other significant conditions con Recto Veginal fistu		_	,		23e. Did tobacc		o the cause of death?
ital Rec	ysician: The law is certificate has b director, page 2 si	e e	25. Was case referred to medical				26. Place of Deatl	24a. Was an autopsy performed 1 Yes 250	? prior to death?	utopsy findings available completion of cause of
Division of V	To the Hospitel or Attending Physician: whin 24 hours after death. To the Funeral Director: After this certification of the Funeral Director. After this certification in the funeral director.	atlon: To B	examiner? 1 Yes 2 No Hi 27. Manner of Death 1t Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 I	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4X Nursing Ho	me 5 Residence 28d. Describe how in		cify)
Divis	To the Hospitel or Attending Ph. within 24 hours atter death. To the Funeral Director: After this completely filled in by the funeral	l Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	y) 			28f. Location (Street City or Town, St	rate)	
	o the Hosi ithin 24 ho o the Fune	Medical	29a. Certifier (Check only one) 2 Medical Examin 29b. Signature and title of certifier	ician: To the best of my kno er: On the basis of examina and manner stated.	ition and/or inv	restigation, in my op	inion, death occurr	ed at the time, date	e(s) and manner as and place, and due Date signed (Mont	to the cause(s)
	r s r ö		30. Name and address of person who cou		n 23a) (Type, I	Print\	0996)	13/64	
ľ	Sta Re gistr		Nail Stoddowd 31. Date filed (Month, Day, Year) JAN 14	32. Registrar's Signa 2004			Cluster	town M	D 216:	20,

		- For	State of Marylan		artment of Hea		-	•	ie.	
		1 - For State Registrar		Cei	rtificate of De	eath	Reg	. No. 2	004	0232
Phy	sicia	Decedent's Name (First, Middle,					2. Date of Death Month	Day	Yeer	3. Time of Death
/M	edica	Hary Hargare					January		004	8:30 A M
Exa	mine	4a. Fecility Name (If not institution, 16 South Verm	To Maria Control of the Control of t		4b. City, Town, or Lo		_	4c. County of		
Fune	ral		6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If	i amsport Under 24 Hrs.	8. Date of Birth	Wa	ashin 9. Birthple	GTON ce (State or Foreign y)
Direc		220-09-8864	1□M 2Q(F 8	5 Yrs.	Months Days F	lours Min.	8. Date of Birth (Month, Day, Y 0ct.26,1	918	Mar	yland
pue *	211	Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				100	d. Inside City Limits
Maryli 1 sho			hington		iamsport				100	WXYes 2 □ No
r 28a		Maryland Was	mgron	*****	10f. Zip Code		100	. Citizen of Wh	nat Countr	y?
and 21215-UU36 be filed within 72 hours after death with the Maryland hat Hygiene. or other than 'natural', or teme 23s or 28s-1 show event if a Medical Experient than collined.			ont Street		21	795		US	SA.	
r dea		11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Was Decedent of Hispa f Yes, specify Cuban, N	inic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race	Americar White, et	
S afte		1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	ed 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Specify:		Specify:		
Z1Z15-UU36 d within 72 hours afl giene. er than "natural", or		15. Decedent		16a. Deced	dent's Usual Occupation	n	16	b. Kind of Busi	Wh i	
within 72 ene.		(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done durir DO NOT use retired)	ng most of workir	ng			o <i>y</i>
filled will Hygien other th		6			Housewife				me	
be fill	á	17. Father's Name (First, Middle, L	_		18.		(First, Middle, Ma	iden Sumame)		
styland 212 should be filed within nd Mental Hygiene. marked other than	F	Franklin Bruce 19a. Informant's Name/Relationsh	•	10b Mailin	ng Address (Street and	Joseph			Fish	-
re, Maryla s 1 and 2 should f Health and Men item 27 is marke	1	Patti L. Myers								
ore, of Hea fitem		20a. Method of Disposition	20b. P	lace of Dispos	outh Vermor sition (Name of natory or other place)	D. D.	ate 20	c. Location - Ci	ity or Tow	1 21/95 n, Stete
Pages nent of I		XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	2 Publichal Iloui 2/9/6		Mem. Park	Jan. 16	,2004 Wi	lliamsn	ort	Maryland
Saltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth monity or other fraumatic event	ouce.	21. Signature of Cineral S. V. L			Name and Address of SDOPNE FUNC			rramop	01111	adi y rana
n goes	a	111 (951/11.	Kele	42.	5 S. Conocc	ocheague	St. Wil	Liamspo	rt,M	21795
	н		complications that caused the death nly one cause on each line.	n. Do not ente	er the mode of dying, so	uch as cardiac or	respiratory arrest	,	A Ir	pproximate iterval Between Inset and Death
Physicia /Medic		Immediate Cause (Final disease or condition resulting in death)	-a Alzh		iers 1)seas	se			Jears
Examin			Due to (or as a consequ	. 5	Heart F	Failure				1
*	4	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ		TIEGOT I	andz				months
cuted nd ransit	Eveminer	Cause (Disease or injury that initiated events	. Klral	Fall	lore					weeks
/ 6U, e be executed /sician and e burial-transit	ŭ	resulting in death) Last	Due to (or as a consequ	uence of):						
- u : u			d							
that the death certifica ed by the attending phe detached for use as the	Dhveirian/Mad	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ncv				224 D-10		
death cert a attendin d for use	10	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		ay Year
at the C	ay d	9 Unknown	9□ Unknown							
Ords, Prequires that seen signed be detained by	1		s contributing to death but not resu	ulting in the un	iderlying cause given in	Part I.	23e. Did tobac		ute to the	cause of death?
w require	100						1 🗆 Yes	2 No 31	Probab	ty 4 □Unknown
	Completed						24a. Was an autopsy	prio	or to comp	findings available letion of cause of
VICAL NEC sician: The law certificate has be							performed		th? Yes 2[□ No
	8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	0.4		Check only one)	- Co.		
g Physe er this		A	28a. Date of Injury	28b. Time of	28c. Injury at		e 5 Residence 8d. Describe how		(Specity)	
LIVISION or Attanding after death. Director: After	ita	1 Natural 5 Pending 2 Accident investiga	ition	Injury	Work? M 1 ☐ Yes	2 🗆 No				
IVIS or Atta ter de irecte	Certification.	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	of be led 28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	28	Bf. Location (Stree City or Town, S	t and Number (or Rural R	oute Number,
DIVISION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	2		Physician T- 41- 1	ala da da da da da da da da da da da da da						
Hos 24 ho Fune	odica i	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my know xaminer: On the basis of examinat and mammer stated.	wiedge, death tion and/or inv	occurred at the time, d estigation, in my opinio	ate and place, ar n, death occurre	nd due to the caus d at the time, date	e(s) and manno and place, and	er as state I due to th	ed. e cause(s)
To the within Fo the	M	29b. Signature and title of certifier	0000	γ	29c. License nur	mber	29d.	Date signed (A	Month, Da	y, Year)
5		1 11	Italle	V	MDOO	52136	١ ١	1131	200	14
h		30. Name and address of person w	ho completed cause of death (Item		Print)			1 -1		
`y		Williamspor	t family Practice		Byrkit Dr	Willia	magart M	D 21	795	
	State istrar	1/1/81 2 97	32. Registrar's Signat	ture	A.		1			

			For State	State of Maryland / I			giene	0000
		_	Registrar 1. Decedent's Name (First, Middle, Last	1	Certificate of Deat	2. Date of Dea	leg. No. CUUI	4 UZ3Z5
	Physic		Philip lee	Trach		Month	Day Year	3. Time of Death
	/Medi Examir		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location		4c. County of Dee	1
			Washington Co	unta Hospita	al Hagerst	NW5	leasher	aton
	Funeral		Social Security Number 6. Se	TAL OF E	Months Days Hour	der 24 Hrs. 8. Date of Birth s Min. (Month, Day Apr. 23,		tholace (State or Foreign ountry)
	Director		219-20-1565 Usuel Residence of Decedent	76	Yrs.	Apr.23,	1927	Maryland
	land ow		10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
	Many First	to	Maryland Washing	ton	Williamsport			1 ☐ Yes 2X No
	or 28s	lrec	10e. Street and Number		10f. Zip Code		log. Citizen of What Co	ountry?
	23a 23a	Funeral Directo	15802 Falling Wat	ers Rd.	2179	95	Ü	SA
	er der Itame	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ※XXDivorced	NYWes 2 No 1945— If Yes, Give Year or Dates: 1947	1 □ Yes XXNo Speci	ity:	Specific	hite
5-0036	72 hours after deeth with the Maryland natural', or tame 23a or 28a-1 ehow disal Enaminat must be notitled at	ted	15. Decedent's Edu	ication 16a	Decedent's Usual Occupation		16b. Kind of Business	
215	within 7. ene. then "n	ple	(Specify only highest grad Elementary/Secondary (0-12)	(e completed) College (1-4or 5+)	(Give kind of work done during m life. DO NOT use retired)	lost of working		industry .
7	filed with Hygiene. other the	Completed	10		Truck Driver		Transpor	tation
pu	be fill d oth	Be	17. Father's Name (First, Middle, Last)		18. Mo	ther's Name (First, Middle,	Maiden Sumame)	
3	should be find Mental him marked of	۴	Harvey Albertus	Teach		Ethel Irene	Dick	
Maryland	d 2 sho th and th and traum		19a. Informant's Name/Relationship (T)		. Mailing Address (Street and Num			
ē,	ges 1 and 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23s or 28s-1 show or other traumatic event, the Medical Engine		Scottle Teach - 20a. Method of Disposition	20b. Place of	4241 M Falling V f Disposition (Name of		20c. Location - City or	
JO III	Pages nent of I nnt: If it		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	ternoval from State	ry, crematory or other place)			
Baltimore,	교문문증 .		21. Signature of Typeral Service Ligens	ee/ Greenr	awn Mem. Park 22. Name and Address of Fac 05borne Funera	Gility Lana D. A	IIIIamspor	
Ö	Depa Impo eny ii		1////	(M		reague St.Wil	Liamsnort /	21795
İ			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death. Do ne cause on each line.	not enter the mode of dying, such	as cardiac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or andition resulting in death)	Pulmara	Fu Eucho	1 Sua		Onset and Death
8	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	11 510 -		o surges
	Lxammer	_	Sequentially list conditions,	0.				
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	OI):			
<u>,</u>	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	of):			
8760,	The law requires that the death certificate be executed the sbeen signed by the attending physicien and bage 2 should be detached for use as the burial-transit			1.				
9	tificat ng phy as th	Physician/Medical						
Вох	leath certifica attending ph d for use as th	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of del	ivery
	the at	Sici	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month	Day Year
P.0	that the d ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions co					
ds,	ires that signed t d be det	i by	Pin 311	ichoding to death out not resulting if	i the underlying cause given in Par		oacco use contribute to es 2□No 3×Pr	othe cause of death? obably 4 DUnknown
Records,	w requir been si should	Completed	Capalana	Actorian	Sclerosis			
Re	he law has ge 2 s	шb	- Car o may	141100101	201019313	autops	y prior to o	topsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical		OC DI-		No 1 □ Yes	25 No
<u>></u>	S S D	To B	examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	lospital: Dunpatient 2 ER/Ou	Other	ce of Death (Check only on Nursing Home 5 Reside	***	c(hr)
u of	Jing Ph J. After th funeral		27. Manner of Death 10 ■ Natural 5 □ Pending	28a. Dale of Injury (Month, Day Year) 28b. 1	Fime of 28c. Injury at mork?		ow injury occurred	ary)
Siol	Attending r death.	catic	2 Accident investigation		M 1 ☐ Yes 2	□No		
Division	or Atl fter d Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	pital ours a erai (29a. Certifier 1D Certifying Phy	Plainty To the best of my key use he	Taraban da marana arang arang arang arang arang arang arang arang arang arang arang arang arang arang arang ar		Harris Company	
	Hos 24 hc Fun etely	edicai	(Check only 2 Medical Exami	ner: On the basis of examination an and manner stated.	d/or investigation, in my opinion, di	eath occurred at the time, d	tese(s) and manner as ate and place, and due	to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	₩ E	29b. Signature and little of certifier	1/2	29c. License numbe	r 2	9d. Date signed (Month	n, Day, Year)
	OXI		1 the Co	mild -	00050	0826 7	aniena	110 2004
7.2	5		30. Name and address of person who co	ompleted cause of death (Item 23a)	(Type, Print)	pans Read	(10,2001
×	-		William F. Bod	enherner, 1	10 20311 Lag	pand Read,	Browkere	1,00 Z17/3
i de	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma		epartment of i Certificate of				004	02326
	Physici		Decedent's Name (First, Middle, La Marvin Tr	umpower				Jan. 8		Year	3. Time of Death 9:20am
	/Medic Examir	_	4a Fecility Neme (If not institution, given Williamsport N		ome		4b. City, Town, or Lo William		4c. County Was	of Deeth hing	ton
	Funeral Director				78 Y	rs. If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug • 1	0,1925	9. Birthpla Count MD	ace (State or Foreign ry)
	a-f show	ctor	Usuel Residence of Decedent 10a. State 10b. County MD Washir.	ngton	10c. City, Town Clear	or Location Spring				10	d. Inside City Limits X□ Yes 2□ No
	h with the 23a or 28 st be no	ai Director	10e. Street end Number 12402 Nesbitt	Ave.		10f. Zip Code 217	22	1	0g. Citizen of V U . S		γ?
020	within 72 hours after death with the Maryland ene. than "natural, or items 23a or 28e-f show the Madical Examiner must be notified at	by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Morried	12. Wes Decedent BArmed Forces? 1 Types 2 No Market Person No. 1 N		13. Was Decedent of if Yes, specify Cub 1 ☐ Yes 2 ☒ No		cify Yes or No- Rican, etc.)	Blac	- America k, White, e white	tc.
Baltimore, Maryland 21215-0020	d 2 should be filed within 72 hours af it and Mantal Hyglene. It is marked other than "natural", or traumatic event, the Modical Exam	Completed by	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12) 12th grade	ducation ede completed) College (1-4or 5	16e. E	Decedent's Usual Occu Give kind of work done life. DO NOT use retire Warden	pation during most of working d)	ng	Corre Faci		nal
land 2	should be filed nd Mental Hygin marked other imatic event, to	To Be Co	17. Father's Neme (First, Middle, Lest				18. Mother's Name Etta	(First, Middle, Slayma		ө)	
Mary	ind 2 should alth and Men 27 is marke		19a, Informant's Name/Relationship (Thomas Trumpow	(Type, Print) Ver son	19b. 8.5	Mailing Address (Stree 18 Count	and Number or Rure	l Route Number Lane Bo	r, City or Town, Donsbo	State, Zip () 21713
imore,	permit. Pages 1 and Department of Health important: if itam 27 any injury or other tr once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		20b. Place of I Cedar	Disposition (Name of crematory or other plants Lawn Ceme	etery Jan 20		20c. Location Hagers		
Balt	permit. Departimport. any Inj		21. Signature of Funeral Service Lice	hu		13607 Nat	Edwin Tho Lional P:	ike Cle	ear Sp	al Ho	ome,Inc ,MD 21722
	Physician		23a. Part. Enter the diseese, or com shock, or heart failure. List only	-		ot enter the mode of dyi	ng, such as cardiac o	r respiratory arr	est,	, ,	Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	a HVEUN	WW/A Due to (or as a co	onsequence of):				7	2 DAYS
x 68760,	as that the death certificata ba axecuted igned by the attending physician and be detached for use as the burial-transit	/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Ceuse (Disease or injury that initiated events resulting in death) Last	c	Due to (or es e co						
Box	death cert ne attendin ed for use	Physician/M	Part II. Other eignificant conditions of	contributing to death bu	it not resulting in	the underlying cause gi	ven in Pert I.	23b. Did to	bacco use cor	tribute to	the cause of death?
s, P.O.	requiras that the yean signed by th hould be detache	by Phy	ATHEROSCLEROS	515.				1)X(Y	es 2□No	3 🗆 Probe	ably 4 ☐ Unknown
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tal R	The ata h		CACHEXIA 25. Was case referred to medical				26. Place of Death	(Check only or	•	10	Yes 2□ No
ξ	hysicia his cert il direct	To Be	examiner?	Hospital:		Datient 3LI DOA	her: 42 Nursing Hor	ne 5 Reside	ence 6 🗆 Othe		
ion	nding Path. r: After to funara	ation:	27. Menner of Deeth 1 ⊠Neturel 5 □ Pending 2 □ Accident investigation		Year) 28b. Tii Year) Inj	ury Wo	ryat rk?]Yes 2 □ No	28d. Describe h	ow injury occurr	ed	
Division	al or Atte s after des i Directo d in by th	Certification:	3 Suicide 6 Could not be determined		ry - At home, farr :. (Specify)	n, street, factory, office	2	28f. Location (Si City or Town		er or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funaral director.	edicai		hysicien: To the best of miner: On the besis of end menner sta	exemination end/						
		Σ	29b. Signature end title of certifler	N		29c. Licen:			9d. Date signed	(Month, D	ey, Yeer)
	16X'		30. Neme end eddress of person who	completed ceuse of de	eeth (Item 23e) (T		700		ANNARY	8,	4007
Y	4.15		TEN & LIMINE	154N.	HZTIZAH		WILLIA	MEROIZ	I, MS	5	21795
	Sta Registr	ite ar	31. Date filed (Month, Day, Yeer)	2004 32. Registre	er's Signature	Constall 1					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Albertus Tosten, Sr. January 2004 12:50 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Williamsport Nursing Home Williamsport Washington Hours Min. 8. Date of Birth (Month, Dey, Year) Aug. 17, 1919 If Under 1 Year Birthplace (State or Foreign Country)
 Mary land 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Days 1 X M 2 ☐ F 84 Yrs. Director 214-14-6216 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Maniel Hyglane. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any fujury or other traumatic event, the Medical Examinar must be notified at once. 10d. inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐XNo Directo Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18237 Manor Church Road 21713 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ģ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Loader Brick Manufacturer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Cleveland Tosten Ella Mae Guessford 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 18237 Manor Church Road Boonsboro, Maryland 21713 Beverly A. Black - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 1-10-04 Hagerstown, Maryland 21. Signature of Funeral Service License OSborne Funeral Home. P.A. 425 S. Conococheague St.Williamsport, Maryland 23a. Part1. Enter the dealise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CELL CARGINOMA OF LING /Medical Immediate Ceuse (Final disease or condition resulting in death) 2 MONTHS Examiner Physician/Medical Examiner or Attending Physician: The lew requires that the death cartificate be axecuted attanding physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the da within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the a completaly filled in by the funeral director, page 2 should be dateshed. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 208 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending Injury 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 154 N. ARTICAN 32. Registrar's Signature State Registrar

			1	For State Registrar		State o	of Maryla	and / Dep <i>Ce</i>	artmen <i>rtificat</i>	nt of H	lealth D <i>eath</i>	and M	lental Hyg	giene Reg. No. 2 (004	02328
		. = =		Decedent's Name (/	First, Middle, La	st)							2. Date of Dea	ith Day	Year	3. Time of Death
	1	Physicia /Medic		Margaret	Elizabe	th THO	MAS						Janu	ary 8,	2004	0050 M
	3	Examin	_	4a. Facility Name (If no			ımber)		1			of Death			ty of Death	
		esti E		Homewood			7 4 //	and the state of an		illia r 1 Year	amspo	r 24 Hrs.	9 Date of Rief		ningto	on place (State or Foreign
		Funeral		5. Social Security Num 214-10-270		i⊟M 2.2XTF	7. Age (in y	rs. last birthday Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day Dec. 6	, Year) 1907	Cou	ontry)
	100	Director		Usual Residence of Di			70					1	DCC. 0	, 1507		
		ylanc how		10a. State 1	Ob. County		10c.	City, Town or L	ocation							10d. Inside City Limits
		e Ma	cto	Maryland		ngton	1	William:								1 ☐ Yes 2 🛣 No
		death with the Maryland ms 23a or 28a-1 ehow rmust be notified at	Director	10e. Street and Number 16505 Vir		Weniie			10f. Zip	p Code 2179	95			10g. Citizen o USA		ntry?
		eath v	Funerai	11. Marital Status	.ginia h		cedent Ever in	n U.S. 13.	Was Dece	edent of H	ispanic O	rigin? (Spe	ecify Yes or No-	14. R	ace - Amer	
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinat must be notified at once.	by Fun	1⊠ Never Married 3 □ Widowed 4		Armed F 1 Yes If Yes, G	2⊠No ive		If Yes, spe 1 ☐ Yes		Specify		Rican, etc.)	Spec	ack, White	white
	ခု	tural		15	5. Decedent's E	ducation		16a. Deci	edent's Usu	ual Occup	ation			16b. Kind of	Business/Ir	ndustry
	215	within 72 ene. then "nat	Completed	(Specify Elementary/Second	only highest grader (0-12)) (1-4or 5+)	(Giv life.	DO NOT L			ist of worki	ing			
	21	filed wit Hygiene other the	Con	12		1			cle:	rical						supplier
	Maryland 21215-0036	be file	Be	17. Father's Name (Fit Elmer Eug									e <i>(First, Middl</i> e, Roderuc		ame)	
	Z	should ind Men marke umatic	ို	19a. Informant's Nam				19h Mai	ing Addres	s (Street			al Route Numbe		n. State. Zi	o Code)
	Ma	th an		Eleanor Br									rstown,	-		1.1
	altimore,	s 1 an f Hea item 3		20a. Method of Dispos				b. Place of Disp cemetery, cre	osition (Na	ime of other plac	(e) T		Date	20c. Location	n - City or T	own, State
	Ë	Pages nent of I int: If its iry or o		1 □ Burial 2 ☒ 1 □ Donation 5				Hagersto	,			1/09	9/04	Hagers	town,	Maryland
	alti	permit. Departmine importe any inju		21. Signature of Fund	aret Service Lice	nsee	n, -		2. Name a	ind Addre	ss of Fac	lity	MINNIC	H FUNE	RAL H	OME
व्रं	8	20 = = 9			att.		jusu	we					l., Hage		, Md.	A CONTRACTOR OF THE PARTY OF TH
1					failure. List only	one cause on	each line.	leath. Do not e	nter the mo	de of dylr					2	Approximate Interval Between Onset and Death
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Y			S			,							1 Yes	202 No	death?	2 🗆 No
T	Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referre examiner?		Hospital: 4	1200			Ott			h (Check only o			n en e
dd	o	Phys rthis raldii	. To	1 ☐ Yes 2 N 27. Manner of Death	.0	1 1	Inpatient e of Injury onth, Day Yea	2 ER/Outpati 28b. Time	of	28c. Iniui	v at	Nursing Ho	ome 5 ☐ Resident			ify)
J,	On	Attending P	atlor	1 Natural 2 Accident	5 Pending investigated		onth, Day Yea	r) Injury	М	Wo.	rk? Yes 2[□No				
MARGA	Division of Vital	l or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	4 200. Fid.	ce of Injury - A	At home, farm, s	treet, facto	ry, office			28f. Location (S City or Tox		mber or Ru	ral Route Number,
2	Q	Hospitel or 24 hours afte Funerel Dir tely filled in														
		To the Hospitel or A within 24 hours after To the Funeral Direction plately filled in by	Medical		Certifying P	miner: On the										
		To the within 2 To the comple	ž	29b. Signature and ti	itle of certifier	2/			29	9c. Licens	se numbe	r		29d. Date sig	ned (Month	, Day, Year)
				1//	1/1/					Y) 2	68	06	2	Kency	Va 8	,2004
		X		30. Name and address	ss of person who	completed ca	use of death	(Item 23a) (Typ	Print)	Di		Hrs	1018	6000	115	12/242
	V)`	ate	31. Date filed (Month	Day Year)	32.	Registrar's S	Signature	100	JU	<u>e</u> /	100	JC/JX			11/12
		St Regist			JAN 09	2004	Balina	· A.	Sperk	es						

		1	For State	State	of Marylan		artmen			and M		giene Reg. No. 2	004	02329
ah.			Registrar 1. Decedent's Name (First, Midd	le. Last)				0 0, 2			2. Date of De.	ath		3. Time of Death
	Physici	600 (80)	Robert	-	ler-						Month	Day	Year ()	2147M
1	/Medic		4a. Fecility Name (If not institution				4b. City.	Town, or	Location o	f Death		4c. Cour	nty of Death	
	Examin	er	Dorchester Ge						bridg			Do	rches	ter
3	<u> </u>		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde	1 Year		24 Hrs.	8. Date of Birt	th		nplace (State or Foreign untry)
135	Funeral Director		218–16–7679	1 X M 2□F			Months	Days	Hours	Min.	Month, Da June 29	y, Year)), 1925	Mar	vland
L 1	* *		Usual Residence of Decedent				1				Juic 23	1,1,20		7
	/land		10a. State 10b. County	,	10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	Man Man	tor	MD Dor	chester				Cam	bridg	e				1 XYes 2 No
7	r 28g	irec	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·		10f. Zip	Code				10g. Citizen o	of What Co	untry?
4	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f ehow he Modical Exercities maint be notified a	Funeral Director	410 Shepherd	Ave.					21613			U.	S.A.	
3	after death w	Jer	11. Marital Status	12. Was Do	ecedent Ever in U Forces?	I.S. 13.	Was Dece	dent of Hi	ispanic Original	gin? (Spe	cify Yes or No Rican, etc.)	- 14. P	lace - Ame	ncan Indian,
9	after or Its	Ē	1 Never Married 2 Ma		s 2 No		1 ☐ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,		Spe		hite
21215-0036	rell, o	by	3 Widowed 4 Divorce	Year or	Dates: WWI	I		292,10				Эре		iii ce
5	72 h	etec		nt's Education est grade complete	d)	(Give	dent's Usu kind of wo	rk done d	during most	t of workir	ng	16b. Kind of	Business/	Industry
2	ithin	npi	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT U					gon	struc	tion
7	e filed within al Hygiene. I other then '	Completed	11	1			Ca	rpen		da Nama	(Cinch Adiabatha			CLOIT
D	be filed within 72 hours after death with the Marylan ital Hygiene. Ad other then "neturel; or items 23e or 28e-f show other then "neturel; framiner main he notified a seent, the Medical Examiner main he notified a	Be	17. Father's Name (First, Middle								(First, Middle.		ame)	
<u>¥</u>	should be nd Menta marked imatic ev	ဥ	Samuel Jame								Pritche			F- 0- (-)
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic ev <u>once.</u>		19a. Informant's Name/Relation	ship (Type, Print)							l Route Numb			up Code)
()	and lealth m 27 her t		Peggy Tyler		wife	4 I U			ave.,		bridge,	20c. Locatio	1613	Town State
Baltimore,	ges 1 t of H H ite or ot		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal fro	m State	cemetery, cre	matory`or	other plac					•	
Ë	Fa trent: jury		*4 Donation 5 Dother (Dor	cheste						Cambr		
32	Depariment Mapor Indiana		21. Signature of Juneral Service	Censee							omas Fu		21613	
_	0.0 ≥ • a		John W.J.	your							nbridge		21013	Approximate
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	t only one cause o	n each line.									Interval Between Onset and Death
	Physician		tmmediate Cause (Finat disease or condition	-a.	ladde	er c	and	er	-m	eta	stal	re		10 wells
	/Medical Examiner		resulting in death)	Due	to (or as a consec	quence of):								
	LAdimilei		Sequentially list conditions, if any, leading to immediate	b	ende	Ju.	eu	re						Much
	sit set	ine	cause. Enter Underlying Cause (Disease or injury	< □	to (or as a consec	danie oi).								
	and and I-tran	Examiner	that initiated events resulting in death) Last	c	to (or as a conse	quence of):								
1760,	ate be executed hysician and the burial-transit	aiE			,									,
687	phys the	edica		d										
9 ×	death certifica e attending ph d for use as th	/Me	IF FEMALE:	23c If yes	outcome of pregn	ancy						234	Date of del	iven
Вох	atter for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Liv	e birth 2 Fet	al death 3	□Ectopic p		,				Month	Day Year
o.		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		known	3	O(1) 61 (3	poc., y ,						
<u>α</u>	The law requires that the tte has been signed by thogge 2 should be detache		Part II. Other significant condi-	tions contributing to	death but not re	sulting in the i	underlying	cause giv	en in Part I		23e. Did t	obacco use c	ontribute to	the cause of death?
ds,	sign d be	l by									10	Yes 2 □ No	3 □ Pr	obabiy 4 🗆 Unknown
Record	v requ	Completed									24a. Was	an 24	h Ware au	ntopsy findings available
3ec	The law cate has page 2 s	mpi							<u> </u>		auto	psy ormed?/	prior to death?	completion of cause of
a E				7							1 ☐ Yes	212/No	1 🗆 Yes	2□ No
Vital	ician. certific	Be	25. Was case referred to medic examiner?	Hospitaf:		358/0		OA Oth	00		(Check only		Dah /C	-74.3
o	Physician: this certific ral director,	. To	1 Yes 2 No			28b. Time		UA	4 - 140	-	me 5 🗆 Resi 28d. Describe			опу)
	ding l h. After funer	tion	1 ■ Naturat 5 ☐ Pend	ling (N tigation	ite of Injury fonth, Day Year)	Injury	М	28c. Injur Wor 1 □	k? Yes 2.∐	No				
Si	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Pl	ace of Injury - At h	nome, farm, s	treet, facto	ry, office					ımber or Ru	ural Route Number,
Division		Certification:	4 Homicide	bı	ilding, etc. (Spec	ity)					City or To	wn, State)		
	Hospitel 24 hours a Funeral I tely filled		29a. Certifier 1 Certify	ing Physicien: To	the best of my kn	lowledge, dea	ith occurre	at the tir	me, date ar	nd place,	and due to the	cause(s) and	manner as	stated.
		Medical	(Check only 2 Medical one)	Examiner: On the	e basis of examin anner stated.	ation and/or i	nvestigatio	n, in my a	pinion, dea	ath occurr	ed at the time,	date and place	e, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certif	ier			25	c. Licens	e number			29d. Date sig	ned (Mont	h, Day, Year)
	- >- 0		ah a x 1	11-				400	599	73		1/1=	Vind	
•			30. Name and address of person	n who completed o	ause of death (Ite	m 23a) (Type		100	~ [[/	·	110	107	
				a Johnson				ble	St.,	Camb:	ridge,	MD 21	613	
	St	ate	31. Date filed (Month, Day, Yea	(r) 3	2. Registrar's Sign				•					
	Regist		JAN	1 3 2004	1 Pales	B.	Const. Pri							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Veirtz 2004 11:09 A.M Frances Januarv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth ADI II., 9. Birthplace (State or Foreign Country) Maryland 5 Social Security Number 6 Sex Year) 1920 **Funeral** 83 Days Hours Min. 1 ☐ M 2 ☑ F 217-10-0912 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show event, the Medical Examiner must be notified at Maryland Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Winchester Street 21701 U.S.A. Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give* Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 'nstural', or 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) 10 Material handler Custom Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
eny injury or other traumatic eveni
angue. Stanley J. Michael Mary M. Wickham ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra M. Baer/Niece 12 Winchester Street, Frederick, MD 21701 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Olivet Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Jan. 19, 20 4 Frederick, MD 21. Signatu of Funeral Service Licenses Name and Address of Facility Keeney & Bastord Funeral Home illand 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** orgett ve Caileur /Medical Due to (or as a consequence of) Examiner coronav disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed sectension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 3□ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide i 24 hours af • Funeral D letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mp. D0054636 01/19/2004

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed W. Haque, M.D., 700 Montclaire Avenue, Frederick, MD 21701

		•	For State Registrar	State of Ma	•	epartment of H Certificate of L		lental Hygier Reg. l	/ / / / /	02331
I	Physicia		Decedent's Name (First, Middle, La Monroe Lave					2. Date of Death Month January	5, 2004	3. Time of Death 7:45 p M
	/Medic Examin		4a. Facility Name (If not institution, giv				Location of Death		4c. County of Death	roll
3.0	Funeral Director		3369 Water Stree 5. Social Security Number 183-07-4530		(In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jun 30,	ar) 9. Birth	nplace (State or Foreign untry) nsylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Ba-fah	Director	Maryland Carı	coll			Manchest			1 ☐ Yes 2√2 No
	with th	i Dire	10e. Street and Number 3369 Water Stre	et		10f. Zip Code	21102	10g.	Citizen of What Co USA	untry?
136	filed within 72 hours after death with the Maryland Hygiene. the than natural; or items 23a or 28a-f ahow int, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 Yes 28 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
9500-6121	d within 72 hou jiene. r than "naturi ine Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5		Decedent's Usual Occup. Give kind of work done of ife. DO NOT use retired Farmer	ation during most of work)	ing 16b	Kind of Business/l	
12 pu	d ta b	Be	17. Father's Name (First, Middle, Last			I CLIRCI		e (First, Middle, Maid a Beachte]		
Maryland	2 should and Men Is marke eumatic	ဥ	Milton Wentz 19a. Informant's Name/Relationship (Margaret Wentz,			Mailing Address (Street &	and Number or Rur	al Route Number, Cit	y or Town, State, Z	
aitimore, l	l an Heali		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑	Removal from State	20b. Place of D	Disposition (Name of crematory or other place	e)		Location - City or	Fown, State
Baltin	permit. Pages Department of the Importent: If ite any injury or of once.		*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		St. JC	22. Name and Address	s of Facility E	line Fune: , Hampste		
~	7 P		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each lin	10.	t enter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as	a consequence of	be meta,	rtatic	melano	ng	
	Nosp	Examiner	Sequentially list conditions, if any, leading to immediate nature. En a lin entring Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of					
58760,	cate be executed physician and the burial-transit	edical Ex	resulting in obality Last	d	a consequence of):				
Box (ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli Month	very Day Year
ds, P.O	n requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but	ut not resulting in	the underlying cause giv	en in Part I.		co use contribute to	the cause of death?
Division of Vital Records,		Completed						24a. Was an autopsy performed	? prior to o	topsy findings available completion of cause of
Vita	ysicien: The is certificate ha director, page	Be	25. Was case referred to medical examiner?	Hospital:		i Oth		h (Check only one)		
on of	ing Ph n. After th funeral	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injui (Month, Da)	ry 28b. Ti	me of 28c. Injur		nme 5 Residence 28d. Describe how in		sify)
Divisi	To the Hospitel or Attending Phwithin 24 hours after death. To the Funesal Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not to determined	9 Place of Inju	ury - At home, farr c. (Specify)	m, street, factory, office		28f. Location (Street City or Town, St		ral Route Number,
	e Hospite 24 hours e Funeral letely fille	Medical C	29a. Certifier 1 Certifying P. (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and	death occurred at the tir for investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)		Me	29b. Signature and title of certifier	ant, u	7 .P.	29c. Licens	e number	29d.	Date signed (Month	
	WITT S		30. Name and address of person who						nster, n	nd. 21157
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		ar's Signature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0337 AM JERRY WETZEL **ANUARY** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAITIMORE HOPKINS 7. Age (In yrs last birthday) JOHNS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 30, 1944 Birthplace (State or Foreign
Country) 6. Se 5. Social Security Number **Funeral** Months Davs Hours 1 M 2□ F 213-42-4060 59 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10h County 10c. City. Town or Location 10a. State or 28a-f show the Medical Exercities count be notified at 1 TYes 2 No Director Adams Littlestown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 146 Georgetown Rd. 17340 tams 23a death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 (1) Yes 2 □ No If Yes, Give Year or Dates 1 964-68 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) construction worker/employed residential/commercial Elementary/Secondary (0-12) then College (1-4or 5+) Pages 1 and 2 should be filed a nent of Health and Mental Hygic int: if item 27 le marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Norman A. Wetzel Virgie Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane E. Wetzel/ wife 146 Georgetown Rd. Littlestown, PA 17340 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 KBurial 2 Cremation 3 Removal from State permil. Page:
Department of Important: If any injury or once. Mountain View Cemetery 1/6/2004 Union Bridge, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Fulleral Service Licenses 6 E. Broadway Union Bridge, MD 21791 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PLEURAL EFFUSIONS METASTATIC WEEK /Medical Due to (or as a consequence of): **Examiner** PANCREATIC 6 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last CANCER Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of). P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 X No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 🗆 No 2 X No 1 Yes 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3 DOA Certification; To 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical poletely (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Fayne E. Soche, MD RES-000 2004 WIL ANUARY 3, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 BALTIMORE, MD 21287 JAYME E. LOCKE 600 NORTH WOLFE STREET 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 JAN 0 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

		-	For State Registrar	State of Maryland		rtment of Ho			ene g. No. 200	4 02334
	Physicia	an	Decedent's Name (First, Middle, Last)				-	2. Date of Death Month	Day Yea	3. Time of Death
	/Medio	al	Mary Margaret Wa 4a. Facility Name (If not institution, give sti	eet and number)	T	4b. City, Town, or	Location of Deat	January	2, 2004 4c. County of De	2:00 P
	Examili	eı	Chester River Ma	nor		Cheste	rtown		Kent	
	Funeral Director		220-32-8551	7. Age (In yrs. last 90	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Apr. 22,	rear)	irthplace (State or Foreign Country) Maryland
	land ow		Usual Residence of Decedent 10a, State 10b, County	10c. City, T	own or Loc	ation				10d. Inside City Limits
	a-f sh	ctor	MD. Kent	Ga	1ena					1 XYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	s 23a	rai	116 W. Cross Stre	et . Was Decedent Ever in U.S.	13 V	21635	enanic Origin? (9	necify Ves or No-	USA	nencan Indian,
336	be filed within 72 hours after death with the Maryland nat Hygiene. dother than "natural", or Items 23a or 28a-f show event, I'm Medical Exactinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married ③□ Widowed 4 □ Divorced	Armed Forces? 1 Yes 27 No If Yes, Give A. Year or Dates:		/as Decedent of His Yes, specify Cubar ☐ Yes 2 XNo	Specify:	o Rican, etc.)	Black, WI	
Maryland 21215-0036	72 hou		15. Decedent's Educa (Specify only highest grade		6a. Deced	ent's Usual Occupa kind of work done d O NOT use retired)	ition uring most of wo	rking	6b. Kind of Busines	
2	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			, ,		O II	_
2	filed v Hygie ther t	ပ္ပိ	11 th 17. Father's Name (First, Middle, Last)	0	11	<u>Iomemaker</u>	18. Mother's Nar	ne (First, Middle, Ma	<u>Own Hom</u> aiden Sumame)	e
<u>a</u>	lid be ked o ic eve	To Be	Leonard Durham				Mary	Anthony		
аī	es 1 and 2 should be filed within of Health and Mental Hygiene. of Health and z7 is marked other than r other traumatic event, the M	-	19a. Informant's Name/Relationship (Type	a, Print)	19b. Mailin	g Address (Street a	nd Number or Au	ıral Route Number,	City or Town, State	, Zip Code)
Σ.	and 2 ealth m 27		Fay Miller	20h Blass		Box 153,	Chester	town, Mar	yland 21 Oc. Location - City	
2	Pages 1 nent of H int: ff ite iry or ot		20a. Method of Disposition 1 □ Kurial 2 □ Cremation 3 □ Re	moval from State Ceme	atery, crem	atory or other place Cemetery	1/7/	bu-	rumpton,	
altimore,	permit. Pages Department of I Important: If it eny injury or o		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	-		•	1			
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	Dhomban		23a. Part 1. Enter the disease, or compic shock, or heart failure. List only one Immediate Cause (Final	cause of ach line.	$\overline{\mathbf{D}}$	and mode of dying	,,		.,	Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Du⊎ to (or as a consequen	ce of):					years
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of injury	Due to (or as a consequen	ce of):					
	sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequen	ce of);					
8760,	tate be ex physician the buria	dicai E	d.							
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3□	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
σ.	juires that t n signed by ild be detac	þ	Part II. Other significant conditions cont	ributing to death but not resultin	ig in the ur	derlying cause give	en in Part I.	23e. Did toba		to the cause of death? Probably 4 □Unknown
Vital Records,	The law requirente has been singled and a sage 2 should be	Completed						24a. Was an autopsy perform	ed? death	autopsy findings available o completion of cause of ?
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			To.	1720-2	ath (Check only one		
6	Attending Physician: r death. ector: After this certifics by the funeral director, I	유	1 ☐ Yes 2 No Ho		Outpatien		Nursing F	fome 5 Residen		pecify)
O	ding f th. After funer	tion	Natural 5 Pending	(Month, Day Year)	Injury	28c. Injury Work M 1 🗀 Y			. Inquity Cookings	
Division of	P Pite	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	the Hospital hin 24 hours the Funeral hpletely filled	Medicai (29a. Certifier (Check only one) Certifying Physical Examination	cian: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim estigation, in my op	e, date and place pinion, death occu	a, and due to the cau urred at the time, dat	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within 2: To the complet	Me	29b. Signature and title of certifier	e	>	29c. License	number 4 9	9	d. Date signed (Mo	nth, Day, Year)
,			30. Name and address of person who con	explored cause of death (Item 23	Ba) (Type,	Print)	Ch	ester	Town	and
	Sta Regist		31. Date filed Month, Day, Year) JAN 0 9	32. Redistar's Signature	J.	Sports		X.	,	

Richard Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 15 per FH, G828, 02/03/04dhb Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 4 1255 AM Richard T. Williams ANUAPY **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner GLEN BURNIE AMME ARUNI DE NORTH ARWINEL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 (Months Day) Year) 4 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Mi SSouri 490-36-9956 1 X M 2 □ F 69 Yrs. Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 27 is marked other than "natural" or items 23a or 28e-f show treumetic event, ite Madical Examinat must be nutified at 1 XYes 2 □ No Arnold Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21012 30 Fox Runway Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Types 2 No Korean If Yes, Give War Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 Ĭ No Specify: Specify: Black ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Depot -2vrs 6 yrs Salesman 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t and 2 should be fi Health and Mental F tem 27 is marked ot Atlean Perry Evently Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arnold, Md. 21012 Vera M. Williams(Wife) 30 Fox Runway f Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1 - 16 - 04Baltimore, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Lavry B, Keese MOO 483 821 West St. Annapolis, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCICEATIZ METASTATIC Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, because to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes 2 17No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury at Work? After thi 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 2004 0-45149 o completed cause of death (Item 23a) (Type, Print) GLEN BURNIE 30. Name and address of person w 21061-Hospital Drive ONABATO 32. Registrar's Signature 31. Date filed (Month, Qay, Year) State

DHMH 17 Rev 1/2001

Registrar

		1	For State of Mar		partment of He		R	eg. No. 2	004	02336
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Dear Month	Day	Year	3. Time of Death
	/Medica	al .	JACQUELYN N	MARIE Y.				7	04	8:08 A M
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			30 LOCUST ST., APT. 419			IINSTER	8. Date of Birth			lace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 7. Age 1	(In yrs. last birthda 70 Yrs.	Months Days	Hours Min.	(Month, Day, 2 / 4 / 1 !	Year)	COLO	lece (State or Foreign try) RADO
	Director	-	Usual Residence of Decedent				2/1/1.	7 7 7	100330	20130
	yland		10a. State 10b. County	10c. City, Town or					11	0d. tnside City Limits
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	th the	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of	What Coun	try?
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	ems ems	Funeral	11. Maritat Status 12. Was Decedent Ev Armed Forces?		Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ice - Americ ack, White, (
36	or it	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No	Specify:		Spec	ity: WHI	TE
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. do ther then 'natural', or items 23s or 28e-f show event, the Madical Examiner relative matified at	q pa	15. Decedent's Education	16a, De	cedent's Usual Occupa	tion		16b. Kind of I	Business/Inc	dustry
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ğ	be filed ttal Hygi of other event, I	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Nam				4
<u>ja</u>	should be filed within and Mental Hygiene. 8 marked other then umatic event, the M	P	DAVID H. PR			HELEN			10001	-
Maryland	9 is a 2	0	19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street a					
	and lealth m 27 her tr		DENNIS KUNDIN - SON		OLD WAS	UTMGION	4	20c. Location		
Baltimore,	Pages 1 ar nent of Hea ant: If item ary or other	1	20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, c	rematory or other place BRANCH CE				-	R, MD.
Ë	t. Pa ntmen rtent:	1	*4 □ Donation 5 □ Other (Specify) IV. 21. Signature of Pure 25 rvice Licensee	LEADOW E	22. Name and Address	***				
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	/Medical Examiner		resulting in death) Due to (or as a	consequence of):						
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0	ng Ph ter th neral		27. Manner of Death 1 Datural 5 ☐ Pending (Month, Day)	Year) 28b. Tim	y Work		28d. Describe h	ow injury occ	urred	
Sion	Attending ir death. ector: After by the fune	atlc	2 Accident investigation		M 1 🗆 1	res 2 □ No				
Division	or Atter after de Directe in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, . (Specify)	street, factory, office		28f. Location (S City or Tow		nber or Rura	il Route Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Decrifying Physician: To the best of	f my knowledge d	eath occurred at the time	e date and place	and due to the	salise(s) and	manneras	tated
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	147		30. Name and address of person who completed cause of de	ath (ttem 23a) (Ty	pe, Print)	11 0		¥	:	
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		-	For State Registrar	State of Maryland		artment of H rtificate of L			giene Reg. No. 20	04	02337
П			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		ELIZABET	H ANN YINGL	ING-H	OSSLER		JAN.	1, ^{Day} 2004		12:55PM
Á	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		th	4c. County of		
			174 WILLIS ST.			WESTMI	NSTER If Under 24 Hrs	To Day of Dia	CARR		loss (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	Hours Min		Year)	Coun	lace (State or Foreign try) LAND
	Director	-	216-60-8929 Usual Residence of Decedent	30	,			1/22/1	907	MIXI	. ПАМО
	and and		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mary Fed	ğ	MD. CARRO)LL W	ESTM:	INSTER					M∑Yes 2 No
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	h with	Funeral Director	174 WILLIS ST.			21157			US.	A	
	deat	ner	11. Wanta Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No- to Rican, etc.)		- Americ	an Indian, etc.
0	or ite	Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give			Specify:		Specify:	WHI	-ਧਾਸ
Š	urai',	d by	3 Widowed 4 Divorced	Year or Dates:	100 Door	desta Havel Oscur	-tion		16b. Kind of Bu		
21215-0036	be filed within 72 hours after death with the Maryland at Hygiene. A let Hygiene do they then "netural", or items 23a or 28a-f show do ther then "netural", or items 23a or 28a-f show event, the Maxilcal Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	orking	100. Killa of Bu	311162271116	Justry
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<u>a</u>		To Be	STEVE	ISON B. YING	GLING		JOANN	E L. EV	ANS		
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ore	of He fiten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Campus I from State	emetery, cre	sition (Name of matory or other place	(e) h / -	Date / O. 4	20c. Location -	•	
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Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other 20028.		21. Signature of File ral Service Licens	99	1	2. Name and Addres					
	⊈ □ E ∈ Ø		23a. Part1. Enter the disease, or compl	in the death of the death		4 E. MA				MD	Approximate
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	he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d 9☐ Unknown	eath 5[Other (specify)					22,
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	icien: Th certificate ector, pag	e C	25. Was case referred to medical				26 Place of Di	1 ☐ Yes eath (Check only o		☐ Yes	2 NO
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			> Steph John	1,NO		D33	572		1/5/0	M	
	WIL		30. Name and address of person who o								4 - 7
			STEPHEN SIKORS			HINGTON	RD.,WE	STMINST	ER, MD.	. 21	15/
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Station Text													3. Time of	Death
## STATUS Control of Section of Control of				Victor Ira Zuck									1:07	рΜ
Honewood Retirement Center Washington Sear Y Age (in ye set brings) User Washington Sear Sea					mber)		4b. City, To	wn, or Loc		January	1			
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The control of the co		Funeral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Y	rear If	Jnder 24 Hrs.	8. Date of Bir	th			or Foreian
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Registrar JAN () 8 / () (4 Andrew 17 Breakly		Sta Registr		JAN 08 2004	edesa o orgnature	An	whit							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 02339 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5:00 AM **Physician** Hdam ત્રવ Ann /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Battimore ett Alt, MORE rive 119 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2√2√5 80 1923 June3 WestVirginia 235-30-0009 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral, or iteme 23a or 28a-f show Examiner must be notified at 1 Yes & No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30 Left Wing Drive 21220 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iten any injury or other traumatic event, the Medical Exemples once. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates: Completed by 3 SWidowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FranklinSquare Elementary/Secondary (0-12) College (1-4or 5+) L.P.Nurse Hospital 2yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Seeders ၉ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Theresa Adams/daughter 30 LeftWingDrive Baltimore Md 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/24/04 Baltimore MD Bayview Crematory 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee on 300 Mace Ave. Baltimore MD 23a. Part1. Enter the disease, or demplications that caused the death shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 190 **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-tran ine of Death Due to (or as a consequence of): ician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Division of Vital

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics

Certification: 4 - Homicide 29a. Certifier Medical

2 Accident

3 🔲 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certific

5 Pending investigation

6 Could not be determined

29c. License number DO059841

1 □ Yes 2 □ No

29d. Date signed (Month, Day, Year) 1/22/24

28f. Location (Street and Number or Rural Route Number, City or Town, State)

se ol death (Item 23a) (Type, Print) 30. Name and address of person who completed cause

7 Beacon Road Baltimore, MD 21220 S. Ciciline 31. Date filed (Month, Day, Year)

State Registrar

JAN 3 0 2004

32. Registrar's Signature

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Catherine Louise Anderson Month **Physician** 27,2004 January 12:19AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Center Baltimore Co. Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊡ M 2∏ F 217-78-0600 46 Director Jan. 26,1958 Texas Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Rosedale Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 Manor Place 21237 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2√2√No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Air Filter Co. 12 Years Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raymond L. Inman Janet E. Conaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health as Important: If Item 27 is sny injury or other trau once. Baltimore, Maryland Mrs. Janet E. Inmon (Mother) 1 Manor Place 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □ Donation 5 □ Other (Specify)

21. Signature of Figure 1 Service Vigenses Lawn Cemetery 1/30/2004 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** ung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No perform ormed? 2. No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) + 0 spice 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 2 ☐ Accident 5 Pending investigation To the Hospitel or Attendition 24 hours after death.
To the Funerel Director: A completely filled in by the fu 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 125205 JANUAN, 27, 2004 7 30. Name and address of person who oppipleted cause of death (Item 23a) (Type, Print) N. Charles St. Balto. md 21204 G-BMC 6701 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 3 0 2004 Sec. Registrar

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Catharine

		1 - For State Registrar		State of I	Marylan	d / Depa	artment e rtificate	of He	ealth a Death	ind M		ag. No.	20	04	02	341
Physi	cian	1. Decedent's Name (First,	Middle, Last)								Date of Dea Month	Day		Year	3. Time of	
, /Med		JOHN	Α.			URKHAR					JANUAR?				2330	М
Exam	iner	4a. Facility Name (If not ins					4b. City, To			f Death		4c.	County o			
		ANNE ARUN				la at birth days	ANNA If Under 1		IS If Under 2	A Hrs	9. Date of Birt			E ARU	NDEL ace (State o	r Foreign
Funera		5. Social Security Number 217–16–5382	6. Sex	M 2□F		last birthday) Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Date of Birt)	y, Year)		Counti MARYI	y)	n roreign
Directo)r	Usual Residence of Deced			83		L				8/3/192	20		TAK1 L	MIND	-
yiand		10a. State 10b. 0	county		10c. Cit	y, Town or Lo	ocation							10	d. Inside Ci	ity Limits
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th wi	<u>a</u>	499 MIAMI	STREET				44	883]	JSA			
ire, INIGITY IZITIO Z LZ L3-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Maryland Extended Later continued at	by Funeral Director	11. Marital Status 1 Never Married 2[3XXVidowed 4 Di	Married	12. Was Decede Armed Force 1/TVes 2 If Yes, Give Year or Date	es? □ No		Was Deceder If Yes, specify 1□Yes 2\X		spanic Orig , Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		Black	- America , White, et WHIT	tc.	
21215-UU36 ad within 72 hours aft glene. er than "natural", or . ITE MAJICS! EXECUT	ed	15. De	cedent's Educ	cation		16a. Dece	dent's Usual (Occupat	tion			16b. Ki	nd of Bus	iness/Indu	ıstry	
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Maryland Z nd 2 should be filed of the and Mental Hygie 27 Is marked other r traumatic event, III	To Be	17. Father's Name (First, A JOSEPH H.		RDT							(First, Middle, KNOWN	Maiden	Surname)		
aryla	-	19a. Informant's Name/Re	lationship (Ty)	рө, Print)		19b. Maili	ng Address (S	Street ar	nd Numbe	r or Rura	l Route Numbe	r, City o	Town, S	itate, Zip (Code)	
and 2 and 2 salth a n 27 is		CHERYL R. BU	RKHARD'	Γ					ROAD	-	T 101,	TEM	PLE I	HILLS	, MD	20748
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2		20a. Method of Disposition XXBurial 2 Crem	ation 3m1718	emoval from St	1 6	Place of Dispo cemetery, crei	sition (Name matory or othe	of er place)	D	ate	20c. Lo	cation - C	City or Tow	m, State	
Pag Thent Mant: I		`4 □Donation 5 □ O	her (Specify)			EASANT	RIDGE	CE	м. 1	/31/	2004	TI	FFIN,	, ОН		
Baltimore, permit. Pages 1 and Department of Heal Important: if item 2 any injury or other	- Succe	21. Signatura Pineral S	ervice Licen	91_	0		2. Name and				FINK I					
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Division of a crattanding after death. Diractor: After d in by the fune	Certification;	2 Accident 3 Suicide 6 4 Homicide	investigation Could not be determined	28e. Place o building	f Injury - At h , etc. <i>(Specii</i>	ome, farm, st fy)	M reet, factory, o		'es 2⊡!		28f. Location (S City or Tox	Street and vn, State	d Numbe)	r or Rural	Route Num	nber,
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To tha within 2 To tha	Mec /	29b. Signature and title of	veralle	ech, Mc)			Du	nu <i>m</i> ber 16052			U	26/0	(Month, D	ay, Year)	
132	,	30. Name and address of	Bech, M	ompleted cause 20	of death (lie)	redition	PrinPark	Way	11 a	nha	polis,	M				
Regi	State strar	31. Date filed (Month, Day	, rea <i>r)</i>	32. Reg	distrants Signa	ature	Low	R)								

		1 - For State Registrar	State of Ma	ryland	d / Depa <i>Cer</i>	irtment of F tificate of i	lealth and Death		giene Reg. No.	2004	02342
Physici /Medio		Decedent's Name (First, Middle, Last Joan Scherer Be) ccarino					2. Date of De Month Januar		2004 ear	3. Time of Death 2:35 p ^M
Examin		4a. Facility Name (If not institution, give Franklin Square H	ospital	(1 1-		4b. City, Town, or Rosedale If Under 1 Year			4c. C Ba.	ounty of Death 1timore	
Funeral Director		5. Social Security Number 6. Se 213–34–0884	x /. Age ☐M 2f2☐F	71	st birthday) Yrs.	Months Days		8. Date of Bir (Month, Da Sept. 2.	Ty, Year) 5,193	Coun	place (State or Foreign ptry) Sylvania
Maryland I-f show	tor	10a. State 10b. County Maryland Baltimor		-	Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2X No
th with the 23a or 28s	al Director	10e. Street and Number 3115 Liberty Parkw	ay			10f. Zip Code 21222	?		-	en of What Coun	itry?
Strong that the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental Hygiens and Mental Hygiens is marked other than "naturel", or Items 23a or 28a-f show aumatic event, the Maryland Examinar round be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent E Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba □ Yes 25(No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)		Race - Americ Black, White, pecify:	
within 72 ho ene. then natur	Completed	15. Decedent's Edi (Specify only highest grad	loation le completed) College (1-4or 5+	-)		lent's Usual Occup kind of work done o DO NOT use retired CY Worker		working		of Business/Ind	dustry
uld be filed dental Hygi rked other	To Be Co	17. Father's Name (First, Middle, Last) Arthur Scherer					18. Mother's N	Name (First, Middle McCready			
To, mary your your your your your theath and Mer them 27 is marke other traumatic		19a. Informant's Name/Relationship (T) Hilda Miller (Sist	•		P.O. I	346,		Bridge, V	V. Vi	rginia 2	26711
Page nent o ant: If		20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐ 6 '4 ☐ Donátion 5 ☐ Other (Specify)		Cei	metery, cren View (sition (Name of natory or other plac Crematory	Jar	Date 1.29,2004	Balt		Maryland
Demit. Departr Imports eny inji		21. Signatur of Funeral Service 1995	mely			1407 O <u>l</u> a	Easterr		<u>Esse</u>	me, P.A. x, Mary	Land 21221
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	clana	Hic C	andiou as	1	F	rrest,	/	Approximate Interval Between Onset and Death
Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a								
icate be executed physicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):						
The law requires that the death certific the law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Fetal	death 3	Ectopic pregnancy Other (specify)			23	d. Date of delive Month	ory Day Year
w requires that been signed b	ρ	Part II. Other significant conditions co	ntributing to death but	t not resul	ting in the ur	nderlying cause give	en in Part I.		obacco use Yes 2 🗆		e cause of death?
The law requested has been page 2 should	Completed							24a. Was autor perfo 1 Yes			osy findings available inpletion of cause of
hysician: The this certificate al director, pag	To Be	165 20110	Hospital:	-	R/Outpatien		er: 4 🗆 Nursing	Death (Check only of	dence 6[)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, g	ertification;	27 Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day 28e. Place of Injury	Year) ry - At hon	28b. Time of Injury ne, farm, stre		y at <br Yes 2 □ No	28d. Describe I	Street and I	occurred Number or Rural	I Route Number,
ospital or hours afte uneral Dire	O	29a. Certifier 1 Certifying Phy	building, etc.	mv know	rledge, death	occurred at the tim	ne, date and pla	City or Ton	cause(s) ar	nd manner as sta	ated.
To the Ho within 24 To the Fu complete	Medical	29b. Signature and title of certifier	ner: On the basis of and manner state	ed.	on and/or inv	29c. License				signed (Month, L	
10		30. Name and address of person who co	1	1 1		V (8)	06/			cry 29, 2	2004
Sta		31. Date filed (Month, Day, Year)	32. Registrar		ıre	CT. Lather	wille, 1	Yaryland	2109	3	
Registr	ar	JAN 3	0 2004	P. Care	of the	150	F				

State of Maryland / Department of Health and Mental Hygiene? [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2004ar Jän 26 10:27pM Μ. Brooks Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Rossville Manor Care - Rossville If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 ☐ M 2√2√E 235-40-4774 75 Yrs Feb. 16, 1928 WestVirginia Director Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner count be notified at MD Completed by Funeral Director Baltimore 1 ☐ Yes 2 XNo Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 8746 Jarwood Road or Itams 23e 21237 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after Timed Forces? I □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐Mo Specify: White Specify: 3 Widowed 4 □ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iiit. Pages 1 and 2 should be filed within entment of Health and Mental Hygiene. ortant: If Itam 27 is marked othar than injury or othar traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Western Electric 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Louk Louda Vanpelt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hannah/daughter 8746 JArwood Road Baltimore MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1/31/04 BayviewCrematory Baltimore MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex permit.
Departri 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 0 6 Manths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner C pe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physicien Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy õ in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ of Vital Records, Completed 1 🗌 Yes 2.☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 1 🗌 Yes in by the funeral dir 2 ER/Outpatient 3□ DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1. Natural 2 ☐ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral I To the Hospital completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENST MAGME 31. Date filed (Month, Day, Year) JAN 3 0 2004 32 Registrar's Signature State Registrar

CPM 04-00357 UNK 04-015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? [] [] [] 02366 Marc G. Baladi 1- State Amended Item#28c, Per ME, C828, 2/19/04@ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 14:46 PM Marc Gautier Baladi January 13. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Northbound I-95 @ mile marker 46 Elkridge Howard 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** 1**™**M 2□F 578-60-1393 63 3, Director May 1940 EGYPT Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State ral', or Itams 23a or 28e-f ahov Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3124 Berkshire Rd. 21214 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: Egyptian Specify: ģ 3 ☐ Widowed 4 S Divorced er than "nature . The Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other that Taxi Driver Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Najuib Baladi Guenevive 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 la any injury or other treu once. Meriem E. Sheehy - Ex-Wife 3718 Baltimore St. Balto., MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) / King Memorial Park 1/29/04 Balto. Co., 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licens 2501 Gwynns Falls Pkwy, Balto., Part 1. Enter the disease, or complications the vicused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE INJURIES **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 № Yes 2 □ No 24a. Was an page 2 s autopsy certificate 1 Yes 2 🗆 No or Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6XXXVther (Specify) At SCENE 1⊠Xes 2 No Certification: To this 28a. Date of Injury (M with, Day Year) 28d. Describe how injury occurred DRIVER OF CAR INVOLVEDIN MULTI-27. Manner of Death 28b. Time of 28c. Injury at Work? After ZY6PM 1 Natural 5 Pending 176 Yes 2 □ No investigation 1/13/04 2 Accident 3 Suicide 281. Location (Street and Number or Rural Route Number City or Town, State) N 0 2 TH 80 VND I T Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after INTERSTATE HIGHWAY ATMILE MARKER 46, ELKRINGE, M) within 24 hours a To the Funerel C Hoapitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m O.C.M.E. January 14, 2004 30. Name and addyss of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MARY G. RIPPLE MS 31. Date filed (Month, Day, Year) JAN 3 0 2004 Registrar's Signature State And !

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) William Vincent Bruins 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Health Funeral Director Director Usual Residence of Decedent 10a. State 1. Decedent's Name (First, Middle, Last) Bruins 3. Time of Death Month Day Year 7 209 P1 4b. City, Town, or Location of Death Bel Air Harford 1. Decedent's Name (First, Middle, Last) Social Security Name (If not institution, give street and number) 4c. County of Death Harford Social Security Number 6. Sex 17. Age (In yrs. last birthday) Yrs. 57 Yrs. 10c. City, Town or Location 10d. Inside City Limit				For State Registrar	State o	of Marylan	d / Depa <i>Cei</i>	artment of H	lealth and N Death		ene2004	02345
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title-etcertifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) MD 0721671 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revig Madfes 500 Upper Chesapeake Dr. Bel Air, Maryland 21014	on	ding h. Afte fune	후	1 Natural 5 ☐ Pendin	(Mon			Work	(?		milary occasion	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title-etcertifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) MD 0721671 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revig Madfes 500 Upper Chesapeake Dr. Bel Air, Maryland 21014	S	deat deat ctor: / the	ica	3 ☐ Suicide 6 ☐ Could n	ot be	of Injury - At ho	me farm str			28f. Location (Stre	et and Number or F	lura / Route Number
29a. Certifier Check only one) 29a. Certifier (Check only one) 29b. Signature and title-et certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) MD 072[67] 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Levin Maddess 500 Upper Chesapeake Dr. Bel Air, Maryland 21014	<u> </u>	- 0 -	er:	4 Homicide	ned buildi	ing, etc. (Specify	")	501, Iddio1y, 511155		City or Town,	State)	
MD 072/67L January 26,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Madtes 500 Upper Chesapeake Dr. Bel Air, Maryland 21014	_	spita ours neral filled	C	29a. Certifier 1 Certifyin	g Physician: To the	best of my know	wledge, death	occurred at the tim	e, date and place	and due to the care	se(s) and manner a	s stated
MD 072/67L January 26,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Madtes 500 Upper Chesapeake Dr. Bel Air, Maryland 21014		24 h 24 h e Fur etely	dici	Check only 2 Medical 1	Examiner: On the b	asis of examinat	ion and/or in	estigation, in my or	oinion, death occur	red at the time, date	and place, and du	e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Madtes 500 Upper Chesapeake Dr. Bel Air, Maryland 21014		vithin o the	Me	29b. Signature and title of certifier				29c. License	number	29d	Date signed (Mon	th, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Maryland 21014		⊢s⊢ō		* AND		MD		MD	07711	71 7	GNAGE	76,7004
Kevin Madtes 500 Upper Chesapeake Dr. Bel Air, Maryland 21014		. 7		30 Name and address of necess	who completed save	se of death (Itam	23a) (Tuno		0, -10	0	ar court of	/
		10			1.7	500 U	pper C	hesapeake	Dr. Be	l Air, Ma	ryland 2	21014
Registrar JAN 3 0 2004		Sta	te									
				JAN 3 0 3	2004	Disco M	A Bas	all p				

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No.	2004 02346
	Physici /Medic Examir	cal	al Kuby Dolden Danuary 24	Year 3. Time of Death 2004 3.25 P M ounty of Death
	Funeral	ier	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
- 2-	Director **Now**	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	th with the M 23s or 28s-f	Funeral Director	MD	n of What Country?
036	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Modical Exam net must be tradified at	by	3 ★ Wildowed 4 □ Divorced Year or Dates:	Race - American Indian, Black, White, etc. Decify: Black
21215-0036	e filed within 72 hours al Hygiene. cother then "naturel", vent, the Madical Exe	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind Home Maker Overn	of Business/Industry Home
Maryland ?	2 should be filed and Mental Hygis is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Archie Campbell Josephine Bellamy	ımame)
	# 12 G		Mary Taylor - Cousin 901 Cherry Hill Road, Baltimore, Ma 20a. Method of Disposition 1 National 2 Octomation 2 Deprecial from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locate Company of the place of Disposition (Name of cemetery, crematory or other place)	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature Fin ral Service Licensee Mt. Zion Cemetery 01-31-2004 Lansdo	ervices, P.A.
8	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Its only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	d	
P.O. Box 6	res that the death certificing to the attending by the attending be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Date of delivery Month Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use	contribute to the cause of death?
	iician: The law certificate has b rector, page 2 s	Be Completed	© 25. Was case referred to medical 26. Place of Death (Check anti-case)	4b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vital	Phys r this ral dir	Certification: To E	Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	
DİX	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.			umber or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral (completely filled	Medical	one) and manner stated. 29d Date si	ce, and due to the cause(s)
	D		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ay 24,2004
6.	Sta Registra			

			Fiedse	State of Maryland					1 0001
			1 - For State Registrar	State of Maryland	Certificate of	Death			4 02347
2	- A-70	Marin .	Decedent's Name (First, Middle, Language)	ast)	2 /	Bouin	2. Date of Death		3. Time of Death
	Physici		Pauline	2	brogden		January	ay 21 Zou	4 2:27AM
	/Medio Examir	The said	4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town,	or Location of Death	14	c. County of Dea	
40			JOHNS HOPKINS I	BAYVIEW Care Co Sex 7. Age (In yrs. la	enter Balti	nore			
	Funeral Director		5. Social Security Number 6. 227324955 Usual Residence of Decedent	Sex 7. Age (In yrs. Ia	st birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea OCHUBER //	r) 9. Bii 1926	rthplace (State or Foreign ountry) N.C.
	land		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	Mary -f sh	to	M.D NI	10 Ba	Homone				Yes 2□No
	r 28a	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What C	ountry?
	hours after death with the Maryland tural; or Items 23a or 28a-f show al Examinar must be nutified at	aiD	1616 CliffVIEW	ANENUE	2121	3	2	1.5.A.	
	ems	by Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecrfy Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian, te. etc.
36	or It	γFι	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 Wo If Yes, Give Year or Dates:	1 ☐ Yes 2 No			Specify: B/	
21215-0036	hour tural	ed b	15. Decedent's E		16a. Decedent's Usual Occu		16h	Kind of Business	
15	within 72 ene. than "nai	plet	(Specify only highest g	rade completed)	(Give kind of work done life. DO NOT use retire	during most of work	king	11110 01 00311033	undustry
212	d with giene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Pactory	WORKER		Factory	/
	be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	Bec	17. Father's Name (First, Middle, Las	t)		18. Mother's Nam	e (First, Middle, Maide	n Sumame)	-
<u>yla</u>		10	Paul Mitchell			113318	Bigs		
Maryland	d 2 should th and Mer ?7 Is marke traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Stree 1014 Str. J. J. Ree Washington T.	t and Number or Rur	al Route Number, City	or Town, State,	Zip Code)
	s 1 and if Health item 27 other to		20a. Method of Disposition	An Sop Bla	Washing W. T. ace of Disposition (Name of	c. 20002	-3574.	Location - City or	Town State
Baltimore,	8 = 5		1,⊠Burial 2 ☐ Cremation 3				200.		
들	nit. Paratmen ortant: injury		* 4 □ Donation 5 □ Other (Spec 21 Signature → uneral Service Lice	ify) /9 ·//	D. Notional Mem. 22. Name and Addr.	ess of Facility	all a	ine M	eylend
Ba	permit. Departr Importe any inju	Ų,	(Satrew !	Bull			of BALLIA		
	, i		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death.				11/2 170 e	Approximate
	Pnysician		Immediate Cause (Final	y one cause on each line. ARRHYTI					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque					MINUTES
	Examiner		Securetially list conditions	b. HPOXEN	MIA				MINUTES
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
	and and	Exami	that initiated events resulting in death) Last	c. PNEUMON Due to (or as a conseque					DAYS
760,	n certificate be executed inding physician and use as the burial-transit	caj E		_ '	ORV FAILUR	F			MONTAS
687	physicate physicate	edic		Ld. // /////////////////////////////////	1				
Вох (the death certifical y the attending phi iched for use as th	N/Me	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan				23d. Date of de	livery
	ath	Physiclan/M	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		;у 		Month	Day Year
P.0	that the de led by the a detached t	hys	9 ☐ Unknown	9□ Unknown					
	es of	by F	Part II. Other significant conditions						o the cause of death?
ord	w requir been si should	ted	Diabetes MEII	itus, Chronic		utticiency	,	2 ∐ No 3 ∐ P	robably 4 Unknown
of Vital Records,	a law has b e 2 st	Completed	4 nemia, Hy	PERTENSION, PIZI	OR CARDIA	CARRELI	autopay	prior to	utopsy findings available completion of cause of
<u>e</u>				ANUXIA.			performed?	death?	s 2 No
V:E	Physician: T this certificat ral director, p.	o Be	25. Was case referred to medical examiner?	Hospital:	0:	bor	h (Check only one)		
of	Phys rr this aral dir	 -	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury 2	28b. Time of 28c. Inju	ary at	ome 5 Residence 28d. Describe how inj		acify)
on	nding F th. :: After e funer	tio	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	, ,	ork?]Yes 2 □ No			
Division	ial or Attendir s after death. al Director: Af ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not determine		ne, farm, street, factory, office		28f. Location (Street a City or Town, Sta		ural Route Number,
Ö	rs after all Direction	Cert		building, old. (apadily)			Only or rown, ord	10)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	icai	(Check only 2 Medical Exa	Physician: To the best of my know aminer: On the basis of examination	rledge, death occurred at the ton and/or investigation, in my	ime, date and place, opinion, death occur	and due to the cause(s) and manner a	s stated. e to the cause(s)
	the thin 2 the mplet	Medical	29b. Signature and title of certile	and manner stated.					
	To To		55.5	2010	200	4383	7 A	WWAZV	2/2004
7	1,		30. Name and address of page in who	completed cause of death (Itom	23a) (Type Print)				
	//		WILLIAM GREENOUG	4 5505 Ho.	PKINS BAYULEW (CIRCLE E	PALTIMORE	MD Z	1224
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	29c. Licen 2 C 23a) (Type, Print) PKINS BAYVIEW (1re				
	Registr	201		IODA Z	The MANAGEMENT STATE OF THE STA				

		A	MEND ITEM 30 PER DVR G	State of Ma 827 1/30/04			rtment o tificate				giene 20	04	02348			
	Physicia	_	1. Decedent's Name (First, Middle, Las Miriam O. Breth	t)						2. Dete of De Month January	Dey	Year	3. Time of Death 4:50 PM			
-	/Medica Examine	_	4e Fecility Name (If not institution, give	street and number)				4t	. City, Town, or	Location of Deeth			4.50 IM			
	LAdmine		Crofton Rehab (enter				(Crofton		Anne	e Aru	ndel			
1	Funeral Director		5. Social Security Number 6. Social Security Number 112-56-0630	9X 7. Age □ M 2]X] F	e (In yrs. k	ast birthday) Yrs.		f Under 1 Year If Under Months Days Hours		8. Date of Bir (Month, Da Oct 7,	v. Yeer)	9. Birthpla Countr enns	ce (State or Foreign γ) y1vania			
	2	-	Usuel Residence of Decedent		10- 03-		- 4:					40	41			
	h the Marylan r 28a-f show r notfilled at		10a. Stete 10b. County MD Anne Ar	rundel	TUC. City	r, Town or Loc Croft						100	d. Inside City Limits 1 ☐ Yes 2X No			
	2 0 %		10e. Street end Number 2131 Davidsonvil	1 - D J	Þ		10f. Zip Co		,		10g. Citizen of W	hat Countr	y?			
	ne 23a		11. Marital Status	12. Was Decedent B	Ever in U,S	S. 13. W		2111 It of His		pecify Yes or No o Rican, etc.)	USA - 14. Raca	- America				
21215-0020	or its	Dy ru	1 ☐ Never Married 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Dates:	lo		Yes, specify □ Yes 2【X		Specify:	o Rican, etc.)	1	white, et whit				
5-0	natural', natural', ndical Ex		15. Decedent's Ed (Specify only highest gre	ucation		16e. Decede	ent's Usual C	Occupat	tion	kina	16b. Kind of Bus	iness/Indu	ıstry			
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5 5+	+)				uring most of wo	Killy						
121	led w lygien it, the	3	12	5+		tax	cons			(Fire Addd)	finan					
/lanc	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the M	0 26	17. Father's Name (First, Middle, Last) John Clarence	e Newman						e Olive	Maiden Sumame Fox	,				
Maryland	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, tra. Mental Hygiene.		19a. Informant's Name/Relationship (7 Joanne Breth/dau						nd Number or Ru Lane ri		er, City or Town, S 21140	State, Zip C	Code)			
Baltimore,	8 = 5	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify		20b. Pl	ace of Dispos ametery, cremi	ition (Name atory or othe	of er place)	Date	20c. Location - 0	ity or Tow	n, State			
Balti	pemit. Pa Departman Important: any Injury pnce.		21. Signature of Forneral Service Licen ROHALD S.	Warle, Dire	ctor		Name and A ate Ar 1timor	nato	my Boar		Baltimo	re Si	treet			
	Physician /Medical Examiner		23a. Peri Enter the diseese, or configurations of heart failure. List only of the configuration of the configurati	a Mye	LOD Due to (or	us blow as e conseque	ence ol):		quelier			; I	Approximate intervel Batween Onset and Death			
Box 68760,	ficate be physicials to the bu	ᄝ	edical	edical	Boing	Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of):									1	
	the at	200	Part II. Other significant conditions co	ntributing to death bu	it not resu	tting in the und	derlying caus	se give	n in Part I.	23b. Did 1	obacco use cont	ribute to t	he cause of death?			
s, P.O	s that the		Denselia							1 🗆	Yes 2□No	3 Proba	ibly 4 Unknown			
Records,	The law requires that the death certicate has been signed by the attending page 2 should be detached for use a	חמופת								24a. Was perfo	an autopsy rmed?	avail	e autopsy findings lable prior to pletion of cause eath?			
	The i									101	100 25 NO	1 🗆	Yes 2 No			
/ita	entifica ector,		25. Was case referred to medical examiner?							th (Check only o	ne)		_			
	hysical his call dire	2	1 ☐ Yes 2 15 No 27. Menner of Death 1 15 Natural 5 ☐ Pending	Hospital: 1 ☐ Inpatie 28e. Date ol Injur (Month, Day	у	ER/Outpatient 28b. Time of Injury		Other	at at		dence 6 Other					
Ö	ne Hospital or Attending P n 24 hours after death. Ne Funeral Director: After t pleitaly filled in by the funers	200	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injubulding, etc						28f. Location (S City or Tox	Street and Numbe m, State)	r or Rural I	Route Number,			
	To the Hospital within 24 hours To the Funeral completaty filled	Ballo	29a. Certifier Check on 2 Medical Exam	sician: To the best of iner: On the basis of and manner sta	examineti	vledge, death of investigation end/or investigation	occurred et t estigation, in	the time my opi	e, date and plece nion, death occu	, end due to the rred at the time,	ceuse(s) and man date and place, ar	ner as stat nd due to t	ted. he cause(s)			
	Vithir Comp		29b. Signature/and title of certifier		_		29c. L	icense	number		29d. Date signed	(Month, D	ay, Year)			
			ADITYA	CHOPN	A		DS	570	28		1/22/	04				
		1	30. Neme end eddress of person who o		_	23e) (Type, P					1					
				ROFTON REHAB			MD, MO									
	State Registra		31. Dete filed (Month, Day, Year)	72. Registra	ir's Signati	ure	Ke s									

State of Maryland / Department of Health and Mental Hygiene 02349 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12, Fremont Bell January 2004 10:15 AM^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1708 Light Street #36 Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. June 30, 1944 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 59 Director 328-38-8104 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits or 28a-f show Examinational be notified at MD Baltimore 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1708 Light Street #36 21230 Itema 23a USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Wedical Exameter interest. Funerai unk
12. Was Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 | No U
If Yes, Give
year or Dates: 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) unk College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk | 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore City Police Dept 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Sign at a of Funeral Straice Licensee ROHal de Signature 28 tatend Addatomy Board 655 W. Baltimore Street 70 Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due t as a consequence of Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, pe cate has been sig , page 2 should b 1 Tyes 2 Z No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatierit Other: 4 Nursing Home 5 Sidence 6 Other (Specify)
Injury at 28d. Discribe how injury occurred 2 No 1 🗌 Yes Certification; To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Math 28b. Time of Injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) who col 30. Name and address of person en Han 31. Date filed (Month, Day, Year State JAN 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY 27, **Physician** 2004 11:40 P M CURRAN /Medical 4c. County of Death, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Howard Morningside House ff Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 05/04/1917 9. Birthpface (State or Foreign **Funeral** Months 1 □ M 2 XX PENNSYLVANIA 86 Yrs 170-10-6256 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes XX No Director ELLICOTT CITY MD HOWARD 10g. Citizen of What Country? 10e. Streef and Number 10f. Zip Code Items 23a or U.S.A. 5330 DORSEY HALL ROAD, APT 315 21042 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whife, etc. 1 ☐ Never Married 2 ☐ Married white 1 Yes XXVo Maryland 21215-0036 Specify: 3XXVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Trade Association 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Fitzpatrick Andrew Loftus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10409 May Wind Ct., Columbia, MD 21044 Eileen Gerrity Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Sfate 20a. Method of Disposition Burial 2 Cremation 3 Semoval from State Thomas Aquinas Cem. 2/7/04 Archbald, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME/MARYLAND MORT. KELLY GRAGOR 426 CRAIN HICHWAY S., GLEN BURNIE, MARYLAND 21061 #MO1148 FINK Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List any one cause on each line. Approximate fntervaf Between Onset and Death fmmediate ause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the pasf 12 months? Dav 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use contribute to the cause of death? Division of Vital Records, Be Completed by mentice 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed: 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatienf 2 ER/Outpatient ۴ 1 ☐ Yes 2 No 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check only one) within 2 29c. License number 29b. Signature and title of certific To To D50870 Signal Bell Lane Clarksville mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5003 uzan 32. Registrar's Sinature 31. Date filed (Month, Day, Year) 2004 Registrar

		•		artment of Health and Me ertificate of Death	ental Hyglene .Reg. No.	COO4 0 COO1							
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day								
	/Medic	al	Alice I. Cook	4b. City, Town, or Location of Death	JAN 26	County of Death							
1	Examin	er	4a. Facility Name (If not institution, give street and number) Deaton Medical Center	Baltimore City		N/A							
	Funeral Director		5. Social Security Number 215-24-4520 6. Sex 1 7. Age (In yrs. last birthday 75 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Year) 1/28/1928	Birthplace (State or Foreign Country) MD							
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	, = , = , = , = , = , = , = , = , = , =	10d. Inside City Limits							
	Maryl	tor	MD Baltimore	Parkville		1 ☐ Yes 2 ∑(X o							
	h with the 23a or 28a st be not	ai Director	10e. Street and Number 7306 Park Drive	10f. Zip Code 21234	10g. Citi	izen of What Country? USA							
936	be tiled within 72 hours after death with the Maryland tal Hygiene. Id other than "neturel", or items 23a or 28a-f show event, the Madical Examinar mast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Volume 14 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes XxxXVo Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white							
21215-0036	within 72 ho ine. ihan "netur e Modical	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)									
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Maryland	nd 2 shou aith and M 27 is mar r traumati	-	, , , , , , , , , , , , , , , , , , , ,	ing Address (Street and Number or Rural Park Drive, Parky									
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic as <u>once</u> .		20a. Method of Disposition Date 20c. Location - City or Town, State										
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ita	sien: ertifica ector, p	Be C	25. Was case referred to medical	26. Place of Death									
on of V	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	2	1 Yes 2 DNo Hospital: 1 Dnpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 27. Manner of Death 28a. Date of Injury 28b. Time 28b. Time 28b.	of 28c. Injury at 21	ne 5 Residence 8d. Describe how injur								
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	te signed (Month, Day, Year)												
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	X		30. Name and address of person who completed cause of death (Item 23a) (Type K. DESAIMS University specify hes		d taken	Balhmore mox1883							
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 3 0 2004 32. Registrar's Signature	Look									

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		1 - For State Registrar	State of Maryland	d / Depa <i>Cer</i> i	rtment of I	Health and M Death	Mental Hygier		02352	
Physici /Medic		Decedent's Name (First, Middle, Last)		Cur	minat	am	7	Pay 200		
Examir Funeral Director	ier	01108 1350	M 2015 F	ast birthday) Yrs.	4b. City, Town. But full If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea	9. Bir	thplece (State or Foreign ountry)	
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an y and A 12. 2 should be filed within and Mental Hygiene. ie marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) A UNKNOW 19a. Informant's Name/Relationship (Typ)	e, Print)			18. Mother's Nan	BRLNde, Maid	~	Zip Code)	
Pages 1 and 2 s nent of Health ar ant: If item 27 ie ury or other trau		Penny Stanford 20a. Method of Disposition 1 Description 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. P	72 4	& Golder	I Save #	10 PITOSS Date 200. 8/64 EHS FUDERA	Location - City or	Town, State	
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The COLIGS, P.O. BOX 00/00, The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Bc. If yes, outcome of pregna 1 Live birth 2 Fetel 4 Pregnant at time of do	23d. Date of delivery Month Day Year						
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DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ti	al Certification:	3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phys	28e. Ptace of Injury - At he building, etc. (Specificien: To the best of my knowledge)	wledge, death	occurred at the	time, date and place	28f. Location (Street City or Town, St	ate) e(s) and manner a	s stated.	
To the He within 24 To the Fu	Medical	(Check only 2 Medical Examinone) 29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	tion and/or inv		nse number		Date signed (Mon		
$\widehat{\mathcal{P}}$		30 Name and address of person who co	mpleted cause of death (Item	23a) (Type)	Orth N	lolfe S	treet B	altimore	MO 21287	
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	- A -				,	

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			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Audred Cha	5€		January	19, 2004	10:30 A M
	Examin		4a. Fecility Name (If not institution, give si		4b. City, Town, or Location of Death		4c. County of Deeth	
			2312 Caves Road		Owings Mills		Balt:	more
	Funeral		5. Social Security Number 6. Sex		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director	4	214-14-0983	M 20 F 7 S Yrs.		October 2	3,1925	M.D.
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	aho	50	4/	yills Baltom				1 ☐ Yes 2 ANo
	28a-1	Director	10e. Street and Number	GIRS DEFINI	10f. Zip Code	10a.	Citizen of What Cou	ntry?
	with with		2312 CARES RO	. 1	21117		U.S.A.	
	ours after death with the Marylan rel', or ttems 23a or 28a-f ahow Examiner must be notified at	Funeral		Was Decedent Ever in U.S. 13. \	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Ameri	
10	r tter	Fun	Never Married 2□ Married	1 ☐ Yes ≱☐ No		Rican, etc.)	Black, White,	etc.
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Maryland	12 sho h and 7 la ma trauma		19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or Rura	Mills, MD		0 0000)
	s 1 and 2 should f Health and Men Itam 27 Ia marke other traumatic		Christin's Holfsc 20a. Method of Disposition	20b. Place of Dispo			c. Location - City or T	own, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other once.		1 Surial 2 □ Cremation 3 □ Re	emoval from State cemetery, crem M.J. CAR.	matory or other place)	dul 6	Billowier M	^
Ē	if. Partme		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	9 11 of CHIC.	med 1/28 2. Name and Address of Facility 38	els FINERA	Home	<i>O</i> .
Ba	permit. Departr Importa any inju		(Saturia B		1129 N. CAROLINE ST			
3			23a Part 1 Enter the disease or complin	cations that caused the death. Do not ent				Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cal be on each line.	(ad somet	000		Intervat Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	Corollo nos oras	- D P C	10	
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0	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 5□ 9□Unknown	Other (specify)			
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Records,	signed to	d by				1 🗋 Yes	20 No 3 Pro	bably 4 Unknown
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a			OF Was seen referred to made at		00 Plant (Part)	1 Yes 2	No 1 Yes	2□ No
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of	Phys or this aral di	To To	27. Manner of Death	28a. Date of Injury 28b. Time of	f 28c. Injury at	28d. Describe how i		"SCFINE
on	Attending I r death. ector: After by the funer	tion	Accident 5 ☐ Pending investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	Attendi	ifle	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	at and Number or Run	al Route Number,
Ö	s afte	Certification:	4 _ Homodo	building, etc. (opeciny)		0.19 0. 70	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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`	the H hin 24 the Fi	fedical	one)	and manner stated.				
	To Te	Σ	29b. Signature and title of certifier	11.10	29c. License number		Date signed (Month,	
	2		1 0 looke	emy)	O.C.M.E.	Ja	enuary 20,	2004
	1		30. Naine and address of person who co	mpleted cause of death (Item 23a) (Type,	· ·	timoro *	(am.13 0	1201
100			31. Date filed (Mogth, Day, Year)	20 Designation Signature	1 Penn Street, Bal	сшюте, м	arytana 2	TZUT
	Regist	ate rar	31. Date filed (Mooth, Pay, Year) 2004	The sun It Ages	We .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 316 2004 0755 Richard Chambers ANUE /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** 5421 Morris Avenue #1 Prince George's Suitland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days, Oct 21, 5. Social Security Number UNK 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral 5**5 1**X** M 2□ F Yrs. Director Usual Residence of Decedent deeth with the Maryland 10c, City, Town or Location 10d. Inside City Limits ages 1 and 2 should be filed within 72 hours after deeth with the Maryland to Health and Mental Hyglene.
It of Health and Mental Hyglene.
If item 27 is marked other than "naturel; or items 23a or 28a-f ehow or other traumatic event, III a Medical Examination must be redifficed. 10a. State 10b. County MD Prince George's Suitland 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5421 Morris Avenue #1 20742 USA Funerai Unk 12. Was Decedent Ever in U.S. Armed Forces? rried 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Cosby/FI 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or * 4 □Donation 5 🕅 Other (Specify) in state permit. 21. Signature of Funeral Service Licensee Roma 1 d. S. Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Platt. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscherotic Physician /Medical Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, the attending physician the the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Ď signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 □Unknown 1 □ Yes 2 □ No been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed: 2 No certificate 1 Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 es 2 No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending 1 Natural thin 24 hours atter uses.... o the Funeral Director: Af 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

0 2004

			partment of Health and Mental F ertificate of Death	Reg. No. 1991							
	Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death 3. Time of Death							
	/Medical Examiner	CLARENCE N. COSTA 4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location of D								
	Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Laure1 Novi If Under 1 Year If Under 24 Hrs. Min. Months Deys Hours Min. Apr	Prince George's Birth (Day, Year) (11, 1932 New Jersey							
	enylend ehow d at	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or MD Prince George's Laure		10d. Inside City Limits 1 ☐ Yes 2⁄☐ No							
	with the N s or 28e-f	10e. Street end Number 5 Cross Street	10f. Zip Code	10g. Citizen of Whet Country?							
36	72 hours efter deeth with the Merylend natural; or items 23s or 28e-f ehow deal Examiner must be notified at eted by Funeral Director		20723 3. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	USA 14. Race - American Indian, Black, White, etc. Specify: black							
Maryland 21215-0036	within then.	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	cedent's Usual Occupation ve kind of work done during most of working a. DO NOT use retired) disabled	16b. Kind of Business/Industry							
land 2	Ne veh	17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Mid Leticia Fri								
	d 2 sh th end 7 ie m traum	19a. Informent's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Rurel Route Nu Motts Street Lawnside, N	imber, City or Town, State, Zip Code)							
Baltimore,	Peges 1 nent of He ant: If iten ary or oth	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Specify) in state	sposition (Name of Pate rematory or other place)	20c. Location - City or Town, State							
Balt	Depertition of the control of the co	Ronald S. Wade, Director	22. Name and Address of Fecility State Anatomy Board 655 to Saltimore, MD 21201	W. Baltimore Street							
	Physician	23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, of heart failure. List only one cause on each line.		ry arrest, Approximate Interval Between Onset and Death							
	/Medical Examiner	Due to (or as a cons	c Cardiovascular Dis	seuse years							
	executed in end iel-trensit	Sequentially list conditions, I b. Hertensia Due to (or as e considered)		years							
	ficete be physicle ss the bur	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
Вох	deeth cert e ettendin ad for use	d									
о <u>.</u>	es that the deeth certiged by the ettending be deteched for use by Physician/M			Did tobacco use contribute to the cause of death? Yes 2 1 No 3 Probably 4 Unknown							
Records,	s been s 2 should pleted			Ves an autopsy erformed? 24b. Were autopsy findings available prior to completion of cause of death?							
a E	: The le			U Yes 2UN∪ 1 Yes 20 No							
Zit	Physicien: The rhis certificate rel director, page 1: To Be Co	25. Was case referred to medical examiner? 1 12 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	26. Place of Death (Check or ient 3□ DOA Other: 4□ Nursing Home 5 ☑ A								
Division of Vital	Attending Physic deeth. •ctor: After this by the funerel did	27. Manny of Deeth 1 Thaturel 5 Pending (Month, Dey Year) 2 Accident 28b. Time Injury		ibe how injury occurred							
Divis	To the Hospital or Attending Physician 24 hours after deeth. To the Funeral Director After to completely filled in by the funeral medical Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location City or	on (Street and Number or Rural Route Number, Town, Stete)							
	in 24 hours in 24 hours he Funer pletely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 intedical Examiner: On the basis of exeminetion end/or and menner steted.	eth occurred at the time, date end plece, and due to investigation, in my opinion, death occurred at the tir	the cause(s) and manner as stated. me, date and place, and due to the cause(s)							
	To the comp	2%b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
,		30. Neme end address of person who completed cause of deeth (Item 23e) (Typ	e, Print)	Tan 20, 2004							
	State	31. Dete filed (Month, Day, Year) . Registrar's Signature	o de Cone Way Elliatt	uty MD 21042							
	Registrar	JAN 3 0 2004 Separa St. Apr									

DHMH 16 Rev 6/95

ORIGINAL

			For State		epartment of Health and Certificate of Death		giene 2004	02356
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Frederick Wils	on Dier	ken	Januar	y 27, 2004	10:36 art
	Examin		4a. Facility Name (If not institution, give street an		4b. City, Town, or Location of Deat	h	4c. County of Death	1
			Upper Chesapeake Medic	cal Center	Bel Air		Harford	
	Funeral		5. Social Security Number 6. Sex 1 🗷 M 2 □	7. Age (In yrs. last birtho	Months Days Hours Min.	(Month, Da)	v. Year) Cou	nplace (State or Foreign untry)
	Director		212-03-2193	90 Yr	S.	3/7/19	13 Mar	yland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
	Marylan f show	ō	Marviland Harford	Bel Air	-			1 ☐ Yes 2 XNo
	28a	Director	Maryland Harford 10e. Street and Number	Del All	10f. Zip Code		10g. Citizen of What Cou	untry?
Ċ	death with the Maryland ms 23a or 28a-f show	Ö	206 Clarkes Ridge Cour	ct	21015		U. S. A.	
3	death	Funerai	11 Marital Status 12. Was		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-		
် ဖ	after des or items		1 ☐ Never Married 2 Married 1 M	res 2 □ No	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 🖾 No Specify:	o Hican, etc.)		, etc.
, E	ral', c	d b	3 ☐ Widowed 4 ☐ Divorced Year	s, Give or Dates: WW II	TILI Yes ZIZI No Specify:		Specify:	White
5 5	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade comple	eted) (C	ecedent's Usual Occupation Give kind of work done during most of wo	rking	16b. Kind of Business/li	ndustry
<u>.</u> <u>7</u>	vithin ne.	m		ge (1-4or 5+)	ife. DO NOT use retired)		m-1	
Ö	be filed within 72 hours after de ital Hygiene, id other than "natural; or items event, Ite Madical Extrail et a		12 17. Father's Name (First, Middle, Last)	Enc	jineer	ne (First Middle	Televisi	on
and	t be f ntal H ed of	Be		5' - 1				
Z Z	should be and Menta s marked umatic ev	10	Frederick J. I	Dierken	Annie Aailing Address (Street and Number or Ri	Luber		in Code)
Baltimore, Maryland 21215-0036	ages 1 and 2 should b ni of Health and Menti I: If item 27 is marked or other traumatice				Clarkes Ridge Cou			
√ စုံ	1 an Heal Hem 2		20a. Method of Disposition	20b. Place of D	Disposition (Name of	Date	20c. Location - City or T	
ຸ	ages ant of t: If i		1 Burial 2 □ Cremation 3 □ Removal to 4 □ Donation 5 □ Other (Specify)	from State		1/31		
量	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensee	Gardens		004	Baltimore, 1	varyland
B	permit. Departn Imports any injt		m. 7-1 1 5-1	11.50	22. Name and Address of Facility Bruzdzinski Funera 1407 Old Eastern A	I Home P. Venue E	A ssex Marvl	and 21221
			23a. Part 1. Enter the disease, or complications	hat caused the death. Do not				Approximate Interval Between
	Physician		shock, or heart failure. List only one cause Immediate Cause (Final	Bilitard 1	Presemonia			Onset and Death
	/Medical		disease or condition resulting in death)	e to (or as a consequence of)	,			12 days
	Examiner		Sequentially list conditions b.					
	D #	ner	if any leading to immediate	e to (ur as a consequence of)			Ì	
	ecuter and trans	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
0	sate be executed by sician and the burial-transit		Testiting in death) cast	e to (or as a consequence of)	:		1	
8760,	cate b	dical	d	· · · · · · · · · · · · · · · · · · ·				
. 9 ×	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	/Me	IF FEMALE: 23c If yes	s, outcome of pregnancy				
Вох	atten for us	ian	in the past 12 months?	ive birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	rery Day Year
o.	0 0 0	Physician/Me		Jaknown	3 Cities (specify)			
۵.	that the de led by the a detached t	H.	Part II. Other significant conditions contributing	to death but not resulting in the	he underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
) sp	w requires that been signed be should be det	d by				1 □ Y	es 2,⊠No 3 ☐ Pro	bably 4 Unknown
9	w req beer shou	lete	-			24a. Was a	an 24b. Were aut	opsy findings available
Be	The farate has	Completed				autop: perfor	sy prior to co med? death?	opsy findings available ompletion of cause of
taj	iician: The tav certificate has rector, page 2	ပိ	25. Was case referred to medical		26 Place of Dec	1 ☐ Yes ath (Check only or	2 X No 1 ☐ Yes	2 L No
<u> </u>	Physician: r this certifice ral director, I	To B	examiner?	1 ★Inpatient 2 ☐ ER/Outpa	Other		ence 6 Other (Speci	(fv)
Division of Vital Records, P.O	g Phy er thi		27. Manner of Death 28a. [Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury at		ow injury occurred	,
į	ath. or: Att	atio	2 Accident investigation	, worth, buy, buy	M 1 ☐ Yes 2 ☐ No			
<u>.</u>	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e.	Place of Injury - At home, farm ouilding, etc. (Specify)	n, street, factory, office	28f. Location (S City or Tow	treet and Number or Rur n, State)	al Route Number,
0	ital o irs aff ral Di	Cer						
V	Hosp 4 hot Fune ely fil	edicai	(Check only 2 Medical Examiner: On t	the basis of examination and/o	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the our	ause(s) and manner as state and place, and due t	stated. to the cause(s)
K	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Med	29b. Signature and title of certifier	manner stated.	29c. License number		29d. Date signed (Month,	Day, Year!
	7. ¥ 7. 8			m	2005666	フ	Teaus 27	H 2004
	1/4		30. Name and address of person who completed	rause of death (Item 22a) (T.	me Print Jacon dinas	(MD	9	, ,
	10,		602 S. AJWOOU	Red, #106	29c. License number D 0 0 5 6 6 (pe. Print) Joseph Ange BILASR	MD	21014.	
	Sta	ate						
	Registr		JAN 3 0 2004	32. Register's Signature	(Soul			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

Physicia		Registrar		Ce	rtificate of Dea		Reg. No.	
/Medica		1. Decedent's Name (First, Middle, La Franklin		wkins		2. Date of D Month	Day	Year 3. Time of Death
Examine Funeral Director	er		1th Care	yrs. last birthday Yrs.	4b. City, Town, or Locat At More 1 Year If Un Months Days Hou	ider 24 Hrs. 8. Date of 8	irth (2ay, Year)	of Death N/A 9. Birthplace (State or Foreign Country) NC
v	lor	Usual Residence of Decedent 10a. State 10b. County MD Pal	timore	c. City, Town or L	ocation Halethorpe	0000	0, 1331	10d. Inside City Limits 1 □ Yes 2 □ No
death with the Maryland ms 23a or 28a-f show Friesal be notified at	Direct	10e. Street and Number 4230 Hollins Ferry	Road, Apt 310		10f. Zip Code	21227	10g. Citizen of W	hat Country?
5 E	by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or Nican, Puerto Rican, etc.)	lo- 14. Race Black Specify:	USA - American Indian, K, White, etc. Black
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If tem 27 is marked other than "naturelt, or ite any injury or other traumatic event, the Medical Education once.	Completed	15. Decedent's E (Specify only highest gr.	ducation rade completed) Cotlege (1-4or 5+)	(Give	edent's Usual Occupation a kind of work done during a DO NOT use retired)		16b. Kind of Bu	siness/Industry
aryland 2 should be filed and wental Hygic marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last Arzolia Dawkins			Crane Operat	or other's Name (First, Middle Beulah Hill	e, Maiden Sumame	9)
y, Mar and 2 sho balth and n 27 is m ier traum		19a. Informant's Name/Relationship (Shirley Jones / Sist	ter		ing Address (Street and Nu 725 Carolina Av		1111	
Pages 1 Pages 1 nent of Ha ant: If ther ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 页 4 ☐ Donation 5 ☐ Other (Special	Removal from State	0b. Place of Dispi cemetery, cre Gardens of	osition (Name of matory or other place) Cethsemane Cem	etery 1/24/2004		City or Town, State Sount , NC
Balt permit. Departi Imports sny inje		21. Signature of Epiteral Septice Lice	os Victor P. Do	oda, Jr. d	2. Name and Address of Fa narles L. Stever 501 Fast Fort A	acility ns Funeral Home	, Inc.	
68760, Titlicate be executed Wedical Examiner as the burial-transit as the burial-transit	edical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):	coaldiou	ascular	reszik	Approximate Interval Between Onset and Death
	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3[□Ectopic pregnancy □ Other (specify)		23d. Date Mon	of delivery th Day Year
wrequires that been signed b should be dera	ed by PI	Part II. Other significant conditions of	contributing to death but no	\ \	underlying cause given in Pr	Tr.		bute to the cause of death? 3 ☐ Probably 4 ☑Unknown
	Completed	distast	struct?	repu	monor	24a. Wa. auto perf	ormed? de	ere autopsy findings available for to completion of cause of sath?
Of Vital Physician: this certifica al director. p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	ER/Outpatie	04	lace of Death (Check only Nursing Home 5 - Res		(Specify)
Vision C Attending P r death. ector: Affer to	Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 5 Pending investigation 6 Could not be determined	OB Disease of Laives	At home, farm, st	Work? M 1 ☐ Yes 2	28f. Location	how injury occurre (Street and Number own, State)	d r or Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Director completely filled in I	Medical C	29a. Certifier (Check only one)	hysician: To the best of my miner: On the basis of exa and manner stated.	/ knowledge, deat mination and/or in	th occurred at the time, date vestigation, in my opinion,	and place, and due to the death occurred at the time	cause(s) and man date and place, as	ner as stated. nd due to the cause(s)
프로프밭 :	Σ	9b. Signature and title of certifier	0		29c. License numb	er	29d. Date signed	(Month Day Year)
) P. 1 1 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ame and address of person who	John of death	WYW	D330	16/	Januar	y 19,2004 timare

			State	of Marylan	d / Depa <i>Cei</i>	artment rtificate	of F	lealth a Death	and M	lental Hygi	ene 2 (g. No.	004	02358
	Physician	1. Decedent's Name (First, Midd								Date of Death Month	Day	Year	3. Time of Death
	/Medical	Nation Hargaret Dicker Soil							um orla	January	,	2004	1:15 pm
	Examiner	4a Facility Name (If not institution Stella Maris H	-	um <i>ber)</i>			1	•		cation of Death	4c. County		
	Gunnell	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		Timor If Under	24 Hrs.	8. Date of Birth		1 MOre	
	Funeral Director	215-18-5293	1 □ M 2 🂢 F	90	Yrs.	Months	Days	Hours	Min.	October 9,	1913	Mary	lace (State or Foreign ity) Tand
	2	Usual Residence of Decedent		40-0"									Od Incide Obelicate
	anylar ahow	MD Balti			y, Town or Lo arkton	cation						ľ	0d. Inside City Limits 1 ☐ Yes 2 ☐√No
	the M 28a-f cortifie	10e. Street end Number	IIDI C	10		10f. Zip	Code			10	g. Citizen of	What Coun	^
	T or T	18709 Frederick F	load			- 1	120			, ,	USA		,.
	permit. Pages 1 and 2 should be filad within 72 hours efter death with the Maryland Department of Health and Mantel hygiena. Important: if Item 27 is marked other than "natural", or items 23a or 23a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U,	,S. 13.			ispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)	14. Rad	e - Americ	
р.ш. 020	or he	1 ☐ Never Married 2 ☐ Ma	Armed F rried 1 Tes If Yes, G	2X No		1 Yes,speci 1 □ Yes 2)		ın, mexicai Specify:		Hican, etc.)		ck, White,	_
P. 20	ours Fig.	3 🔀 Widowed 4 □ Divorce	d Year or I	Dates:							Specif		ite
1:15 p.r 21215-0020	natu lete	15. Decede (Specify only high	nt's Education est grede completed)	16a. Dece (Give life.	kind of won	Cocup	etion du <i>ring mos</i>	st of work	ing 1	6b. Kind of B	usiness/Ind	dustry
12 12	within and the Man	Elementary/Secondary (0-12)	College n/	(1-4or 5+)		tion li					Fi]	ter co	moanv
	be filad within 72 houelet Hygiena. d other than "natura vent, the Medical avent, the Medical Be Completed	17. Father's Name (First, Middle		<u>u</u>	Froduc	CIOII_I	IIIC V		er's Name	e (First, Middle, M			
, 2004 aryland	Mantel be Marked of Marked	John Wilbur	Bagwell					Cla	ara	01ivia	Fick		
ary,	shou and N and N	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address	(Street	and Numb	er or Run	el Route Number,	City or Town	State, Zip	Code)
27 M	and 2 salth a 27 is	Charles F. Mansur-	son						Annap		21401		
JANUARY Baltimore,	Pages 1 nent of He int: if Iten iry or oth	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	State County	lace of Dispo emetery, crei	natory or ot	e of her plac	(e)	1		0c. Location	-	
TUA.	Pag tment tant:	4 ☐ Donation 5 ☐ Other (Specify)	Garc	dens of			_			Baltimo		
JANUARY Baltimor	permit. I Departm Importar any injui	21 Signature of Funeral Service	Licensee William	am G. Dau		Name and			b Lec	nard J. Ru		. Fune	ral Hone
72	451 44	23a. Part1. Enter the disease, c shock, or heart failure. Lis						_			21214		Approximate
7	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. GALLBLADDER CANCER Due to (or es a consequence of):											Interval Between Onset and Death
Sox 68760,	v requiras that the death certificete be executed been signed by the attending physician and should be dateched for use as the bunal-transit leted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	uence of):										
	as that tha death certingned by the attending be dateched for use a by Physician/M	Part II. Other significant condit	ons contributing to	death but not res	ulting in the u	nderlying ca	iuse giv	en in Part i	1.				o the cause of death?
RUTH DICKERSON Vital Records, P.O.	The lew requiras that tha cata has been signed by the page 2 should be dateche.									24a. Was an perform		ava	ere autopsy findings ailable prior to mpletion of cause death?
RUTH ital Re	cata l									1 ☐ Yes	<u> </u>	10]Yes 2□No
₹ ×	certific rector	25. Was case referred to medical examiner?	Hospital:		55/0 1		Oth			(Check only one			HOCDICE
ō	Phys	1 ☐ Yes 2 🙀 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury	28b. Time o		Bc. Injur Wor	4 🗆 🖂		28d. Describe how			// HOSPICE
on	dlng th. After a fune	1 Natural 5 ☐ Pendi 2 Accident invest	ng (Mo	nth, Day Year)	Injury	М		k? Yes 2□	No				
Division of	i or Attentate after dea i Director d in by the	3 Suicide 6 □ Could	nined 286. Plac	e of Injury - At ho ding, etc. (Specif		eet, factory,	office			28f. Location (Str. City or Town,	eet and Numi State)	ber or Rura	I Route Number,
	To the Hospital or Attending Physician: The lew within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compi		ng Physician: To the Examiner: On the I and ma										
	To th To th comp	29b. Signature and title of certifi	1.1			29c.	Licens	e number		29	d. Date signe	d (Month,	Day, Year)
	. 6		/uit				D	437	125		1/2	18/09	
	19	30. Name and address of person		_								1	
		DR. TARIQ MAI 31. Date filed (Month, Pay, Year		00 DULAN Registrar's Signa		LEY RI	υ.	TIMO	NLUM,	MD 2109	13		
	State		1 7 1311.1.22 1 三次第	NY 1983 Ave.	The Branch	ESPECIAL PROPERTY.							

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Carrie Disque 25 January 2004 10:30 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis Eldercare - Severna Park Severna Park <u>Anne Arundel</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 86 Director 230-07-1820 15, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worde I item 27 ie marked other than "natural", or itams 23a or 28a-1 ehov other traumatic event, the Modical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Anne Arundel West River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5156 Chalk Point Road 20778 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = XXXVo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. illed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3XXVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ng most of working Elementary/Secondary (0-12) Coltege (1-4or 5+) alt. Pages 1 and 2 should be filed with artment of Health and Mental Hygiene. Artant: if item 27 ie marked other than 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Kaiss Martha Callander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn A. Disque (Son) P.O. Box 263, West River, MD 20778 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriał 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 1/30/2004 Davidsonville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Depar Impor any in Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, 23a. Part 1. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final **Physician** Mocardia disease or condition resulting in death) days /Medical Due to for as a consequence of): **Examiner** 51 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (%r as a consequence of): Examine certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ģ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Idinknown Completed Deed 24a. Was an 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performe certificate 1 Yes 2 No 25. Was case referred medical examiner? Be 26. Place of ath Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA 1 ☐ Yes 2 No Other: 4 versing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident investigation М the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Verifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rns Huy M. Hersville MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene? For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** JANUARY 2004 ASHBY DUNNING /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGE If Under 1 Year If Under 24 Hrs. 8 Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** M 2□F 88 Yrs. 7/25/1915 VIRGINIA Director 223-34-9249 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Executions. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No PRINCE GEORGE LAUREL Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12209 SNOWDEN WOODS ROAD 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 🏻 X☐ No Specify: Specify: BLACK δ 3 ∑Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 HEALTH NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE DUNNING LUCY DAWSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DARRELL DUNNING / SON 12209 SNOWDEN WOODS ROAD, LAUREL, MARYLAND 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) BALT/WASH CREMATORY 1/24/2004 LAUREL, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FLECK FUNERAL HOME, INC. Uwa enuis 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failly is. Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA 1-20-2004 /Medical Due to (or as a consequence of): Examiner CHRONIC ATRIAL FIBRILLATION 9-27-2002 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit CONGESTIVE HEART FAILURE 1-9-2002 and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Completed by Physiclan/Medical CARCINOMA PROSTATE 9-4-2002 IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**X** No 3 Probably 4 □Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes X ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel within 24 hours a To the Funerel C filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier duout. D0013668 1/21/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4917 EDGEWOOD ROAD, COLLEGE PARK, MARYLAND 20740 ASHER HUSSAIN, M.D. 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** VIVIAN JOYCE DYSON JANUARY 12,2004 10:30A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE 3603 BLACKSTONE ROAD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | DE Cont. 24, 1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215 28 3497 1 □ M 2 🔀 F 72 MARYLAND Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic avent, the Musical Executive count to notified as MD. BALTIMORE RANDALLSTOWN Director 1 ☐ Yes ¾☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3603 BLACKSTONE ROAD 21133 U.S. OF A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH College (1-4or 5+) and Mental Hygiene. UNKNOWN COMPUTER OPERATOR SOCIAL SECURITY ADM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be be MELVIN TUCKER WILLIE MAE MCKENNY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 22 toles 3 19a. Informant's Name/Relationship (Type, Print) Department of Health ar. Importent: If Item 27 is: HOWARD J. DYSON, SR. (HUSBAND) 3603 BLACKSTONE ROAD RANDALLSTOWN, MD. Baltimore, 1/20/04 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State GARRISON FOREST VET. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CEM. OWINGS MILLS, MD. * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility T. GWYNN LEWIS LEWIS T. GWYNN FUNERAL HOME 21215-6393 -ewis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO . Approximate Interval Between Onset and Death Immediate Cause (Final Priysician A.S.C.V.D. disease or condition 24 HOURS /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner be executed as the burial-tran resulting in death) Last Due to (or as a consequence of): 68760 physician Physician/Medical attending IF FFMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Year Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown X the detached 9 Unknown á signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HYPERTENSION, ATERIAL FIBRILLATION, RHEUMATIC $X\square$ Yes 2 \square No 3 \square Probably 4 \square Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HEART-DISEASE autopsy performed? 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Cther: 4 Nursing Home 5. Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 🗗 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled Hospitel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number D19158 Barry & Gold erson who completed cause of death (Item 23a) (Type, Print) BARRY S GOLD MD. 201 Mil FORD Mill Rd. Ste 105 Batto, md 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN3 0 2004

		State of Maryland / Departm AMEND ITEM #3 PER PHY G827 1/30/04 JH Certific	nent of Health and N cate of Death	lental Hygiene Reg. No.	2004 112362
		1. Decedent's Neme (First, Middle, Last)		2. Dete of Deeth Month Day	3. Time of Death
	Physician /Medical	Earl Walter Davis		January 24	, 2004 11;15am
	Examiner	4e Fecility Neme (If not institution, give street end number) 3013 Ellicott Hills Blvd.	4b. City, Town, or Le		County of Deeth
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If U	Inder 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplece (State or Foreign
	Director	220-28-3479	nths Deys Hours Min.	Jan. 8, 19	32 Maryland
	and w	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1		10d. Inside City Limits
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	with the Maryland n or 28e-f show be notified at		f. Zip Code	1	zen of What Country?
	a 23a		21043	USA ecify Year or No.	14. Race - American Indian,
36	72 hours after death with the Maryland natural; or Items 23s or 28s-f show acel Examiner must be notified at sted by Funeral Director	1 Never Merried 2 XMarried 1X Yes 2 No	Decedent of Hispanic Origin? (Sp. specify Cuben, Mexican, Puerto es 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
21215-0036	natural, adical Ex	15 Decedent's Education 16a Decedent's	Usuel Occupation	16b. Ki	nd of Business/Industry
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/lan	should be filed and Mental Hygin marked other imatic event, I	Harry Calvin Davis	Amanda E	llen Brown	
Maryland	2 sho and ? Is me	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	dress (Street end Number or Run	al Route Number, City o	r Town, State, Zip Code)
	as 1 and 2 should be filed of Haalth and Mental Hyg Itam 27 is marked other other traumatic event, To Be C	20a Method of Disposition 20b. Place of Disposition	(Name of		t City, MD 21043 cation - City or Town, State
E O	@ O	1 □ Burial 2 ◯ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel			nton, Maryland
Baltimore,	parmit. Pege Department of Important: If any Injury or once.		ne and Address of Fecility By Home Cremation The Heckrott		P.O. Box 784 rksville, MD 21029
		23a. Part 1. Enter the diseese, or complications that caused the death. Do not enter the shock, or heart feilure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) a. Motastus VE	on small(ell	LungCone	Onset end Death
,	executed in and idel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	e of):	12	
x 68760,	ficeta be physicia as the bur	Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence death)	of):		
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P.O.	t tha d by tha tached	Part II. Other eignificent conditions contributing to death but not resulting in the underly	ing cause given in Part I.	1 Tee 2	
	requires that that the seen signed by the hould be detache eted by Physe				The second secon
of Vital Records,	aw 2 s b			24a. Was an autop performed?	24b. Were autopsy findings available prior to completion of cause of death?
al R	ystcian: Tha I is cartificeta he diractor, paga			1 T Yes 2	XNU 1 ☐ Yes 2 X No
Vita	Physician: The rthis cartificata ral director, pag	25. Was case referred to medical examiner? 1 Yes 22 No Hospital: 1 Inpatient 2 ER/Outpatient 35	Other	h <i>(Check only one)</i> me 5 X Residence (€ □Other (Specific)
on of	ng Ph tfter th unaral	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation 1 Accident Science	28c. Injury at Work?	28d. Describe how injur	
Division	tral or Attending P ins after death. Fill Director: After t led in by the funare Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
	Ne Hospi n 24 hou Ne Funei plataly fil	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occu Medical Examiner: On the basis of examinetion end/or investigation and manner stated.	urred et the time, date end place, ation, in my opinion, death occur	and due to the ceuse(s) ed et the time, date and	end manner as stated. place, and due to the cause(s)
	withir to the comp	29b. Signature end title of certifier	29c. License number	29d. Dat	e signed (Month, Dey, Year)
	X	full traffmar (1)	1005177) Janu	ary 26, 2004
	5	30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)	ans Stroot ?	and Hamore	Maryland 21231
	State	31. Date filed (Month, Day, Year)	· · · · · · · · · · · · · · · · · · ·		
	Registrar	IAN 2.7 2004 France & Const.			

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 433 AM manue Sanuary 28,2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) Examiner Beetmore Marylana 6. sex 0) University 6 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 23 Yrs. 8. Date of Birth (Month, Pey, Yeer 5/29/1980 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ MX**X**□ F VIRGIN ISLANDS 580-13-5069 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Completed by Funeral Director ANNE ARUNDEL ODENTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 21113 1741 GLEBE CREEKWAY U.S.A. or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XXNever Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 Tes XX No Specify: 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Department Manger Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F VITUS EMMANUEL VIRGIN PROMESSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau 2005. 1741 GLEBE CREEKWAY, ODENTON, MARYLAND 21113 LYANDRA EMMANUEL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition LINGSHILL, ST. CROIX, 1XXBurial 2 Cremation XXXRemoval from State KINGSHILL CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) VIRGIN ISLANDS 21. Sign 191 Funeral Service USA 22. Name and Address of Facility FINK FUNERAL HOME, PA FINK 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 #M01148 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician omorthis disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 1 Nes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannaf of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death.
I Director: Af d in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours a To the Funeral filled f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) Resident 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Megan Dunmaan MD Baltmore MD 31. Date filed (Month, Day, Year) 32. Registrar's gnature State Registrar

			1 = For State Registrar	State	of Marylan	nd / Depa <i>Cer</i>	artment of F tificate of	lealth an <i>Death</i>	id Mental F	lygiene Reg. No		02364
	. 4	Ų.	1. Decedent's Name (First, Middle	, Last)					2. Date of Month	Death Da	y Yeer	3. Time of Death
	Physici /Medio		Dorothy	Ioon Fi	nlov —				Jan	18		7:40AM M
	Examir		4a. Fecility Name (If not institution.		imber)		4b. City, Town, o	r Location of E	Death	4c	. County of Deet	th
,	7		526 Fayett		- 4 4		Cumber1		Hrs. I a a		llegany	
R	Funeral Director		5. Social Security Number 216–14–1892	6. Sex 1 ☐ M 21 ☐ F	7. Age (In yrs. 81	Yrs.	Months Days		Min. 8. Date of (Month, Oct 6)	Day, Year)	2 Mar	thplace (State or Foreign buntry) yland
	and and	}	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Many f she	Į,	MD Allega	anv		Cumbe	erland					1 ☐ Yes 2/☐ No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	puntry?
	h with		526 Fayette	Street			21	502			USA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed F ad 1 Tes If Yes, G	2 to No live	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2🌠 No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
ခို	hour	ed b	15. Decedent	Year or I	Dates:	16a Deced	lent's Usual Occup	ation		16b K	(ind of Business/	Industry
Ċ	n na	Completed	(Specify only highes	t grade completed		(Give	kind of work done	during most of	f working	100.10		
212	d with	Elo	Elementary/Secondary (0-12)	3	(1-4or 5+)	i	register	ed nurs	se		heal	th
-	m - 0 5	To Be C	17. Father's Name (First, Middle, I Louis Frederi		r				Name (First, Mide thy Henri			ter
ary V	shoul nd M mari	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street	and Number o	or Rural Route Nur	nber, City o	or Town, State, 2	Zip Code)
Σ	alth a		Dorothy Pepper/	daughter		526	Fayette :	Street	Cumberla	nd, M	ID 2150	2
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic es <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp			Place of Dispo- cemetery, cren	sition (Name of natory or other place	:е)	Date	20c. Lo	ocation - City or	Town, State
Bail	Departicular Depar		21. Signature Luneral Service Kona Ld	. Wade	Pirecton		Name and Addre ate Anat Itimore,		ard 655 W	. Bal	Ltimore	Street
ā	Physician		23a. Pan). Enter the disease, or shock, or heart failure. List of immediate Cause (Final			th. Do not ente	er the mode of dyin	g, such as car	rdiac or respiratory			Approximate Interval Between Onset and Death uk minutes
	/Medical Examiner		disease or condition resulting in death)	a	(or as a conseq				on without	,		are manages
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	quence of):						
8760,	cate be executed physician and the burial-transit	al Exar	that initiated events resulting in death) Last	C. Due to	(or as a conseq	quence of):						
		dical		d								
O. Box 6	e death certifi the attending ned for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 ☐ Feta nant at time of d	Il death 3	Ectopic pregnancy Other (specify)	,			23d. Date of del Month	ivery Day Year
Ţ.	that the de led by the a detached f	F.	Part II. Other significant conditio	ns contributing to a	death but not res	sulting in the ur	iderwing cause giv	en in Part I	23a Di	d tobacco i	use contribute to	the cause of death?
Hecords,	w requires that been signed should be det	ted by								⊒Yes 2	_	b_#
	elaw hasb ge 2 sl	Completed							— 24a. W au pe 1 ☐ Yes	topsy rformed?	prior to death?	stopsy findings available completion of cause of
Vital	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of	Death (Check onl			
<u> </u>	S . S	2	1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien		4 LI NUISII	ng Home 5 Re	sidence	6 □Other (Spec	cify)
	ding Ph h. After th funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	28c. Injun Wor	ار k?	28d. Describ	e how injur	ry occurred	
<u> </u>	Attending in death. ector: After by the fune	cati	2 ☐ Accident investig	ot be	16 2004		M 1 🗆	Yes 2 No				s with razor
Division		Certification:	4 Homicide determi	ned 288. Place	ling, etc. (Specif	ome, farm, stre fy)	et, factory, office		City or 7	Town, State)	ral Route Number,
_	To the Hospital or within 24 hours after to the Funeral Discompletely filled in		29a. Certifier	Physician: To th	idence	owledge death	occurred at the tin	ne, date and n				b MD 21502
	To the Hospital within 24 hours a To the Funeral I completely filled	edical		xaminer: On the								
	within 2 within 2 To the I	Me	29b. Signature and little of certifier	/	111		29c. Licens	e number		29d. Da	te signed (Mont/	h, Day, Year)
			> Ale		w		D09	157		Jan	18 2004	
		3.	30. Name _n _ dress of person v	who completed cau	use of death (Item	п 23а) (Туре, І	Print)			1		
			Paul Snow M.D	. Dpty M	ed_Ex1	124 W_3	rd_St_Cm	mberlar	nd Md 215	02		
	Sta Regista		31. Date filed (Month, Day, Year) JAN 3 0	32/	Registrar's Signa	ature	net 1					

			For State of Maryla State of Maryla Registrer		rtment of H		Mental Hy	giene2 (104	02365
			Decedent's Name (First, Middle, Last)				2. Date of De	ath	_	3. Time of Death
	Physici		Mary		Gai	2 0	Month	Day 711 29	Year	10:15 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	Januar		2004 tv of Death	10:15
	LXamii	iei	The Johns Hookins Hosp	1201	Dall		CLLI		,	
	Funeral			rs. last birthday)	If Under 1 Year	Mûre If Under 24 Hrs.		th	9. Birtho	lace (State or Foreign
	Director		244-40-8461 1□M XXF 7	4 Yrs.	Months Days	Hours Min.	(Month, De	9, Year) 20, 1929	Nort	lace (Stete or Foreign ltry) h Carolina
			Usual Residence of Decedent				DCPC 2	10,1020	TIVOL	ii Caloilia
	ahow		10a. State 10b. County 10c.	City, Town or Loc	ation				1	0d. Inside City Limits
	Ma-f	ğ	Maryland Baltimore	Mic	ddle Riv	er				1 ☐ Yes 2 📉 No
	h th	Director	10e. Street and Number		10f. Zip Code			10g. Citizen o	What Cour	itry?
	ours after death with the Maryla ral', or Items 23a or 28a-f ahov Ezani et final be restified at		336 Grovethorn Road		21	220		Ţ	J.S.A.	
	ltems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. W		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Ra	ace - Americ	
ထ္	after or Ite	F	1 ☐ Never Married 2 Married 1 ☐ Yes XX No		Yes 2 No	Specify:	nican, etc.)		ack, White,	
93	ours	ž by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		LITES ZAINO	<i>Specny</i> :		Spec	<i>™</i> : Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow in Medical Exanter must be rediffed at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup	during most of wor	kina	16b. Kind of	Business/Inc	dustry
2	ithin se	du	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT use retired	d)	9			
2	filed withi Hygiene. other then	Ö	12		Home Ma				Home	
pu	be filed within stal Hygiene. od other than evant, the Ms	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			me)	
Уa	should be filed withind Mental Hygiene. It marked other than umatic evant, I.a. M.	၉	Delmas Graham				e Peele			
Maryland	0 6 m =	0.3	19a. Informant's Name/Relationship (Type, Print)			and Number or Ru				
	Health tem 27 l		Dale Goins (Husband)	336_G	rovethor	n Road Mi				
Baltimore,	0 0		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State	 Place of Disposi cemetery, crema 	ition (Name of atory or other place	e) Fol	Date	20c. Location	- City or To	wn, State
Ē	Pa ant:			ardens of		Cem. 20	004	Baltimo	ore, M	aryland
at	permit. Departr Importa any inji		21. Signature of Juneral Service Lio-risee)	1 22.	Name and Addre	ss of Facility Bru	ızdzinsk	i Funer	al Ho	me, P.A.
	20 = 20	1 1	Duan W. Jul			astern Av			ırylan	d 21221
	===		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not enter	r the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		ailure					Onset and Death
	/Medical		resulting in death) a. Due to (or as a cons	equence of):	acrure					s days
- 1	Examiner		Sustem	ic In	Flamat	bry Res	DANKO	Sunda	me	3 days
	n ~	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence of):	0	9 170		y Mil	7.70	
	cuted	Examiner	that initiated events	itic t	Breast	Cano	er			2. months
o,	te be executed ysician and e burial-transit	EX	resulting in death) Last Due to (or as a cons	equence of):					1	
8760,	cate be executed physician and the burial-transit	dlcal	d							
9		Jed	IE EE MAN E							
Вох	leath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fe		Ectopic pregnancy			23d. D	ate of delive	ry
	deal ne att	Sici	1 Yes 2 No		Other (specify)			M	onth	Day Year
P.0	that the de led by the a detached t	Å,	9 ☐ Unknown							
	es the	by	Part II. Other significant conditions contributing to death but not r	asulting in the und	derlying cause give	en in Part I.	23e. Did to	obacco use cor	tribute to the	e cause of death?
p	w require been si should I						1 🗆 ነ	∕es 25XNo	3 Proba	ably 4 Unknown
õ	aw requisits been 2 should	ple					24a. Was	an 24b.	Were autop	sy findings available apletion of cause of
Vital Records,	sician: The law requires that the death certifi certificate has been signed by the attending irector, page 2 should be detached for use as	Completed						rmed?	death?	
tal		Bec	25. Was case referred to medical			26. Place of Dea	1 Yes	2 No	1 Yes	2 No
	Physician: r this certifica ral director.	ToB	examiner? 1 Yes 2 No Hospital: 1 VInpatient 2	☐ ER/Outpatient	3 DOA Othe		me 5 Resid		her (Sneciti	3
1)0	g Ph er th eral		27. Manner of Death 28a. Date of Injury	28b. Time of	28c, Injun Work		28d. Describe h			,
<u>, io</u>	Attending r death. actor: After y the fune	atlo	1 SANatural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		Yes 2 □ No				
) Division	or Attendation of Director:	ific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, stree	et, factory, office		28f. Location (S	Street and Num	ber or Rural	Route Number,
Ö	s after	Certification:	uniding, etc. (Spe	211 y)			City or Tow	vn, State)		
de	e Hospital or A 24 hours after of Funeral Diraction betaly filled in by		29a. Certifier (Check only Medical Examiner: On the basis of examiner:	nowledge, death (occurred at the tim	ne, date and place,	and due to the	cause(s) and m	anner as sta	ited.
4	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edical	(Check only one) 2 Medicel Exeminer: On the basis of examinand manner stated.	hation and/or inve	istigation, in my of	pinion, death occur	red at the time,	date and place,	and due to	the cause(s)
	To the within 2 To the complet	Z	29b. Signature and title of certified		29c. License	number		29d. Date signe	ed (Month, E	Day, Year)
			funklo- MO		Ros -	000	-	Tanin	1111 2	9 2001
	10	f	30. Name and address of person who completed cause of death (It	em 23a) (Type, Pr	rint)			JUINA	ry 6	7,004
	10		Eric Weiss 401 No.			Bo	1timn	ro 1	ni	9,2004
	Sta		31. Date filed (Month, Day, Year) 32. Registrat's Sig	nature M	divay	1		· ,		7100
	Registr	ar	JAN 3 0 2004 /	Mari De	And the same of th					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 19a per Inf., G828, 02/02/04/hb litrar State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 0 2 3 6 6 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Cora Elizabeth Cordon 5:17 pm M January 13, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Hospice Center Towson Maryland Beltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 264-86-6327 1 □ M 2√2√F 58 Director August 31, 1945 Milton, FL Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Exeminer must be notified at MD Harford Edgewood 1 ☐ Yes 2 No Director the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 827 Gilway Court 21040 TEA or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 XNo 1 Never Married & Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XXVIO Specify Specify: þ black 3 ☐ Widowed 4 ☐ Divorced "natural", ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Complet than Elementary/Secondary (0-12) College (1-4or 5+) Seamstress 11 0 Sewina peli if Health and Mental Hygie Item 27 Is marked other 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Willie B. Williams Laurice Riley ٥ other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason M. Gordon / Son Husband 827 Gilway Court, Edgewood MAryland 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Milton Cemetery 1/17/04 * 4 ☐ Donation 5 ☐ Other (Specify) Milton, 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Paltimore Maryland 21230 23a. Part 1. Enter the disease, or compliant is t shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of). f any, leading to initiation cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical use as IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) P.O. the 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 3 Probably 4 Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed page certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident Jospital C. 24 hours after dealin. Peral Director; After the full full formal presents of the full formal presents of the full formal presents of the full formal presents of the full formal formal formal formal full formal formal full forma 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie JANUAY 14,2008 1)25200 no 30. Name and address of person who completed use of death m. 3a) (Type, Print) Charles St. Balto. M. 21204 6701 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 3 0 2004 Registra

				Please 1 1 - For State Registrar		aryland / De		x. Ensure Al Health and M Death	lental Hyg	•	02367
		Physic /Medi		Decedent's Name (First, Middle, Last Norman Sylves		hardt			2. Date of Death January	h	3. Time of Death 9:10 am M
T. J.	1	Exami		4a. Fecility Name (If not institution, give Joseph Richey Hospice	·		Baltimo			4c. County of Dea	
0)	Ł	Funeral Director		5. Social Security Number 6. Se 217-01-2687 15	X 7. Ag	e (In yrs. last birthda 88 Yrs.	Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, December 2	9. Bird 27, 1915 Ma	thplace (State or Foreign outry) aryland
5		e Maryland la-f show	ctor	MD 10b. County n/a		10c. City, Town or Baltimor					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
3		ath with the Maryla 23a or 28a-f show	ral Dire	10e. Street and Number 5309 Sipple Avenue			10f. Zip Code 21206		10	og. Citizen of What Co USA	ountry?
50	9600	iges 1 and 2 should be filed within 72 hours after death with the Maryland in of Health and Mental Hygiene. If I fears 23a or 28a-1 show or other traumatic event, the Madical Examinar must be muitified at	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	No	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (Spe lan, Mexican, Puerto I Specity:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
ric l	21215-0036	rithin 72 h ne. hsn *natu	mpletec	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Gi life		pation during most of workind)	ng 1	16b. Kind of Business/	
_		d be filed with antal Hygiene. and other than c event, Ire A	Be Cor	12 17. Father's Name (First, Middle, Last) Norman	Gapha		ectrician	18. Mother's Name	(First, Middle, M Jeourse		Company
S	Maryland	aith and Mental be faith and Mental be 27 is marked ot or traumatic even	To	19a. Informant's Name/Relationship (Ty Thomas L. Poole,		n law 15	illing Address (Street 05 Rayvil			City or Town, State, 2	Tip Code) 21120
ELERS	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 I any injury or other tra once.		20a. Method of Disposition 1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)		cemetery, ci	position (Name of rematory or other plan on Forest	rebrua	ate 2 ry 3,200	0c. Location - City or 04 Owings	Mills, MD
zer	Balt	permit. Depart Import any in		21. Signature of Funeral Service Licens	Can			J. Ruck, I	nc. 530	, Maryland 35 Harford	21214 Rd.
7		Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a	The death. Do not ene. Pene a consequence of):	nter the mode of dyir	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
,	68760,	be executed ician and burial-transit	ilcal Examiner	Sequentially list conditions, any land of the cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as	a consequence of):					
HR	Вох	Attending Physicien: The law requires that the death certificate Lr death. r death. ector: Atter this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the b	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \subseteq Yes 2 \subseteq No 9 \subseteq Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy	1		23d. Date of deliment	very Day Year
LAC	rds, P	w requires that the death been signed by the atte should be detached for	ed by PI	Part II. Other significant conditions cor Diabetes	itributing to death bi	ut not resulting in the	underlying cause giv	en in Part I.		acco use contribute to	
SAPHARD	Vital Records, P.O.	ician: The law re certificate has be rector, page 2 sho	Completed	Of Wassers day of the					24a. Was an autopsy performe	24b. Were aut prior to death?	opsy findings available ompletion of cause of
NAN	Division of Vit	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	ospital: 1 Inpatie 28a. Date of Injur (Month, Day		of 28c. Injun Worl	4 Indising Hom		ce 6 Sther (Spec	m Hospice
NORMAN	Divis	al or Atters s after dea la Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, s :. (Specify)	street, factory, office	28	8f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
Z		To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier 1. ☐ Certifying Phys (Check only 2 ☐ Medical Exemination)	sician: To the best of ner: On the basis of and manner sta	examination and/or i	ath occurred at the tin nvestigation, in my of	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
		To t Com	Σ	29b. Signature and title of certifier 2 150 M	>		29c. License	,		Date signed (Month)	3.
	_	0		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type CC 838	N. Eutaw	St. Ba	Itimore	lanuary 26, MD 21	201
	ŧ	Sta Registr		31. Date filed (Month, Day, Year)	Ro	r's Signature	colle)				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 25, 2004 2004 **Physician** 2:35 PM Richard W. Grewe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Eldersburg

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year)

May I, 1916 Carroll 1523 Woodridge Lane 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11XM 2□ F Yrs. Maryland 214-26-6647 Director 87 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Carroll Eldersburg 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1523 Woodridge Lane 21784 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Deportment of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, Ite Middle once. Elementary/Secondary (0-12) College (1-4or 5+) Seagrams Machinist 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Reed William Grewe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen C. Grewe-Wife 1523 Woodridge Lane, Eldersburg, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery January 30,04 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature Fureral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229 RUCSON / JUSA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASCUM Eu Mus /Medical Due to (or as a consequence of): Examiner coroneur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certilicate be executed burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last and attending physician for use as the buria P.O. Box 68760 Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) nis certificate has been signed by the a director, page 2 should be detached by 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death.

Director: Aft
in by the fun 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral I the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1037949 30. Name and address of person who completed pages of death (Item 25a) (Type, Print) ALEXANDER BOGDASCHEWSKYI M.D. 295 STONER AVENUE, WESTMINSTER, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 3 0 2004 Registrar

GREWE

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RICHARD

Dana Giannino Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-0667 Unpended Item#23a, b, c, 27, Per ME, 6828 2718/04eg

Certificate of Death

Reg. No. AKG 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Dana M. Giannino January 23, 2004 6:39 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Agnes Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2X F 41 Director 220-82-9495 Oct. 11. 1962 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show stical Examiner most be notified at 1 ☐ Yes 2√☐ No Maryland Baltimore Lansdowne Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3146 Ryerson Circle 21227 S. Α. filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ Specify: White 3 Widowed 4 Divorced al Hygiene. f other than "natura ivent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental Hitem 27 Is marked of Pages 1 and 2 should be Frank V. Giannino Barbara Sue Waugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank V. Giannino, father 3146 Ryerson Circle Lansdowne, MD. 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
sny injury or of New Cathedral Cemetery 01-26-04 Baltimore, MD 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ambrose Funeral Home, Inc. Helies S 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Disseminated Inravascular Coagulation /Medical Due to (or as a consequence of): Examiner Staphylococcus Aureus Sepsis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Necrotizing Bronchitis and Bronchiolitis and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ es 2 □ No 24a. Was an ate has page 2 s autopsy performed? certificate Yes 2□No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 XX es 2 □ No 1XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) : After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 24, 2004

State Registrar 31. Date filed (Month, Day, Year)

JAN 3 0 2004

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(iveenberg M. Dr., Year) 32. Registrar's Signature

30. Name and address of person who completed cause of Joseph (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 02370 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** January Edith Ann Heaney 4:30 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lorien Nursing Home Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 68 Days 568-46-1863 1 ☐ M 2 🖫 F Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Howard Columbia 1 ☐ Yes 2 🕱 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Oivorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Retail Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Credit Collections If item 27 le marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Lloyd Heaney Edith King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Patrick Reardon/Son 6338 Red Haven ROad, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permil. Pages 1 Department of H Importent: If ite eny injury or ot once. Jan 30 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 2001 21. Signature of Funeral Service Licensee ²²Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimo N89984 Baltimore, 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner MEUMONIA Sequentially list conditions, if any tending to the collections of the Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No nis certificate has b I director, page 2 sh 24a. Was an autopsy performed 1 Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely CHOCK ONLY 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Meles 00060560 JANUARY 29, 2004 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 BACK RIVER NECK RD BALTIMORE, MD KHETERPAL

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Meser & C

32. Registrar's Signature

				1 - For Amend It Registrar AMENI	cem #25 po DITEM 30	State of er me G830 PER DVR (Maryland 04/14/04 03827 1/30	d / Depa tas 0/04 Gg/	rtment o	f Health an of Death	d Mental Hy	giene Reg. No.200	4 02371
		Physic /Medi		1. Decedent's Name (File	reth &	Evgln		2.y			2. Date of De Month Januar		3. Time of Death
	1	Exami	ner	10101 17	ten Cou	nty Ho	spital		Ha	gerstow	n_iMD	4c. County of D	shington
		Funeral Director		5. Social Security Number 169-24-598. Usual Residence of Dec	3 1	X 0 M 2□ F	7. Ağe (İn yrs. la	Yrs.	If Under 1 Ye		Hrs. 8. Date of Bir Min. (Month, Da July 2	8, 1930 E	Birthplece (State or Foreign Country) Pennsylvania
		faryland show	J.O.	10a. State 10b	c.County ashingt	on	10c. City	. Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ◯ No
		death with the Maryland ms 23a or 28a-f show Trinst ke ny lifted at	Director	10e. Street and Number					10f. Zip Coo			10g. Citizen of What	Country?
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Funerai	333 Mill	unk	12. Was Deced	es?	6. 13. V	Vas Decedent Yes, specify (212740 of Hispanic Origin? Cuban, Mexican, Po	? (Specify Yes or No Jerto Rican, etc.)	US. 14. Race - A Black, W	merican Indian,
	-0036	hours aft	by	1 Never Married 3 Widowed 4	Divorced	1 XYes 2 If Yes, Give Year or Dat			□Yes 2X				white
	Maryland 21215-0036	within 72 ene. then nat	Completed	(Specify or Elementary/Secondary	Decedent's Edu nly highest grad y (0-12)	College (1-4	4or 5+)	(Give life. [nne during most of tired)	working	16b. Kind of Busine	ss/Industry unk
	and 2	be filed htal Hygid ed other	Be	17. Father's Name (First	, Middle, Last)		7		labo	18. Mother's I	Name (First, Middle,		
	Aaryla	12 should be filed within ' h and Mental Hygiene. 7 is marked other then ° raumatic event, tra Mex	2	19a. Informant's Name/I	Relationship (T)	pe, Print)				eet and Number or		er, City or Town, State	e, Zip Code)
		es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre	on		20b. Pla	ace of Dispos	Marti lition (Name of latory or other		oad Peque	a, PA 20c. Location - City	or Town, State
	Baltimore,	permit. Pag Department Important: I any injury c		4 ☑Donation 5 ☐ 21. Six at the of Funds		/ nn - 7	irector	22.	Name and Ad	dress of Facility	1.655	,	
	8	9 9 E 8		23a. Part Enter the dis	sease, of compl	cations that car	used the death.	Ra	ltimore	MD 21	201	Baltimore	Approximate Interval Between
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Due to (o	eptic	Show	ch			/ CXPMI	Oncot and Doath
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		ite be executed lysician and ne burial-transit	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	Due to (or	bct, p	ation	1		31		morths
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hink	.O. Box 6	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	anani		h 2∐Fetald ntattime of dea	death 3 🔲	Ectopic pregna Other (specify,			23d. Date of o	delivery Day Year
13	ds, P	uires that signed t Id be deti	by	Part II. Other significant	conditions con	A A	th but not resul	ting in the un	derlying cause	given in Part I.			to the cause of death?
7	Record	The law requires that the tee has been signed by the bage, 2 should be detache	Completed		Renal		LUNE				24a. Was autop	sy prior to death	
afa	Vital	iclan: certifica rector, p	o Be Co	25. Was case referred to examiner?		ospital:				Other	Death (Check only or	ne)	es 2 No
1	sion of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	ertification: To	27. Manner of Death Natural 5 [2 Accident	Pending investigation	28a. Date of		R/Outpatient 28b. Time of Injury	28c. Ir	4 ☐ Nursing njury at Vork? ☐ Yes 2 ☐ No		ence 6 Other (Sp ow injury occurred	pecify)
	Division	s after de si Directo	Certific	3 Suicide 6 L 4 Homicide	Could not be determined	28e. Place of building	f Injury - At hom , etc. <i>(Specify)</i>	ne, farm, stre	et, factory, offic	СӨ	28f. Location (S City or Tow	treet and Number or in, State)	Rural Route Number,
		s Hospit 24 hour 16 Funera Jetely fille	edical (29a. Certifier 1 (Check only one)	Certifying Phys Medical Exami	ician: To the b ner: On the bas and manne	is of examination	ledge, death on and/or inve	occurred at the estigation, in m	time, date and pla y opinion, death oc	ace, and due to the occurred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
1		To the within To the comp	M	29b. Signature and Ittle of	d low	at m	(n)		00	06 0780	1	P.9d. Date signed (Moi	nth, Day, Year) J 4
					ER HUBERT	Y WASHI	NGTON COI	INTY HOS		GERSTOWN M	D		
	1000	Sta Registr		31. Date filed (Month, Da	y, Year) 3 0 200	A	jistrar's Sîgnatu		de				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** OWARD 200 0 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Dea Examiner HOSPITAL Glen Burnic Anne Aru ORTH Arundel 8. Date of Birth (Month, Day) If Under 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Deys Months Hours 216-30-8566 XXM 2 F 69 Vrs 6/29/1934 Director BALTIMORE, MD Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Itam 27 is marked other than "natural", or heme 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No ANNE ARUNDEL GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1606 LORIMER ROAD 21061 U.S.A. Funeral Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XX☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify. Specify: WHITE ģ 3€ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OIL BURNER MECHANIC L.C. PARKER FUEL CO. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HOWARD W. HODGES SR. RUTH MILKE ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) DONALD WAYNE HODGES, SR. TITAN COURT, PASADENA, MARYLAND 21122 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other plece) 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 29 JAN 04 GLEN BURNIE, MARYLAND GLEN HAVEN MEMORIAL PK. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signa prof Funeral Service 22. Neme and Address of Facility FINK FUNERAL HOME, PA KELLY GREGORY FINK #M01148 426 CRAIN HIGHWAY S, GLEN BURNIE, MD 21061 peess, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. is only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Disease 1040 Examiner Due to (or es a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 4No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury aftar death.

Director: Aft
d in by tha fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Dev. Year) 30. Neme end entress of person who completed cause of death (Item 23e) (Type, Print) 7845 Oakwood Road #106, Glen Burnie, MD 21061 Jørge M. Ramirez, MD 31. Dete filed (Month, Day, Year) Registrer's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene State Registra MEND ITEM4a, 10e, 17&28f PER PHY G828 29 Tificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 0718A M MICHAEL E. HARBIN January 22 2004 /Medical 4e. Fecility Name (If not institution, give street and number)
106
16 South Randolph Road 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore MiddleRiver If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Under 1 Year onths Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**X** M 2 □ F Hours Min Months 8/6/1964 39 Maryland Director 218-68-1924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a, State 10b. County th and Mental Hygiene. ?7 is marked other than "natural", or lieme 23s or 28s-f show traumatic avent, the Micolcal Examinat must be notified as 1 ☐ Yes 2 XNo Director Middle River Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code S A .

14. Race - American Indian, Funeral 21220 Pages 1 and 2 should be filed within 72 hours atter death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iteme 23 16 South Randolph Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY PATTERSON HARBIN Helen Ruth Alban Henry Paterson Harbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Beechwood Avenue Essex, MD 21221 Charlotte Wilson (Sister) other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1/23 2004 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory Baltimore, MD 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, MD 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SUICIDE HANGING BY 10 minutes Physician resulting in death) /Medical Due to (or as a consequence of) Examiner 10 minutes ASPH, XIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. It yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No page Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) **Division** Injury 1 Natural 5 Pending Zanuary 22,2004 O 718 A M 1 = 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 1 🗌 Yes SUICIDE BY HANGING investigation within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or T. wn, State) 10f. S. JANDULPH RD. څ filled in Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier completely (Check only one) Medi To the 29b. Signature and telefier 29c. License number 29d. Date signed (Month, Day, Year) D1866 with WD DEDUCY JANUARY 22, 2004 30. Name and address of person who completed cause of death (Item 23) (Type, Print) GTRIMBLE HILL CT. LUTHERUILR, MARYLAND 21093 PHILIP MILITELLU, MD 31. Date tiled (Month, Day, Year) 32. Regiatar's Signature JAN 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Evelyn W. Hallmon Jan. 21, 2004 6:32pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring MD Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 X F Months 248-86-6469 74 10/27/1929 GA Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 23a or 28e-f ehow the Medical Examiner must be notified at Prince Georges Laure1 1 ☐ Yes 2XXNo Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1016 West Court 29707 USA death Funeral 14. Race - American Indian Herne 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ö Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: þ **3**Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then College (1-4or 5+) Elementary/Secondary (0-12) Administration Asst. Physicians Office other permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other eny injury or other traumeric 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lean Warner Birdie Lee Young ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thersia Jackson /Daughter 1016 West Court, Laurel MD 29707 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Xemoval from State Hallmon Cemetery January 30, 2004 Jenkinsville, * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puperel Service Licensee Victor P. Don, Jr. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiomyopathy resulting in death) /Medical Due to (or as a consequence of). Examiner Encephalopathy, Non Toxic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Ventricular Arrhythmia and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 2√ No 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes XXNo director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXo 1XXnpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 X Matural 5 Pending To the Function after death.

To the Funeral Director: At 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide XX ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of certifier January 22, 2004 D26115 completed cause of death (Item 23a) (Type, (Print) colevile rd baltimore md 21910 Hector Collison, MD 841 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar JAN 3 0 2004

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer Month **Physician** 14:54 HALL ANKARY 27 2004 WILLIAM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY HOSPITAL N/A HOPKINS JOHNS If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1⊠M 2□F Months 61 Sept. 28,1942 Virginia 218-36-5775 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner number outlined at 1 ☐ Yes 2 No Fort Howard Maryland Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21052 9243 North Point Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permil. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural" or then any injury or other traumatic event, the Medical Emerment 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ethel Agnes Patton Cephas Russell Hall ၀ 19a. Informant's Name/Relationship (Type, Print) Step daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pamela G. Palencar 9243 North Point Road Fort Howard, Md Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/30/2004 Towson, Maryland 4 Donation 5 Other (Specify) Hillton Service Corp. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Regare 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Limit one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (5) disease or condition resulting in death) METASTATIC JECK 142 Physician /Medical Due to (or as a consequence of): **Examiner** HEMORTYSIS 24 /four 25 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events ed by the attending physician and detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1/1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate has page 2 2 **2** No 1 ☐ Yes the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number 2 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 HOSPETAL STREET MAZYLAND 21287 COLEN WEEKES THE DHNE Howws MOON WEEFE Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 3 0 2004 Registrar

			1 - For State Registrar	State of Maryland	/ Department of Certificate of		Reg. f	C C C C C C C C C C C C C C C C C C C
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	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "neturel", or itema 23a or 28a-f ahow or other traumatic event, the Modical Evanture must be hydified at	Funeral Director	209 South Monroe 11. Marital Status 15 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	21223			J.S.A. 14. Race - American Indian, Black, White, etc.
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	s 1 and 2 s f Health an item 27 is other trau		Robert Jones 20a. Method of Disposition		4119 St. Geor	ge Ave. A	Apt 3 Balt	imore, MD 21218 Location - City or Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1	Dula	aney Valley	01-2		monium, Md Services P.A.
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ion of	Attending Physician: The rideath. ector: After this certificate haetor: After this certificate hay the funeral director, page	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28 (Month, Day Year)	b. Time of 28c. Injury Wa	iry at	ome 5 Residence 28d. Describe how inj	
Division	in the	Certification:	3 Suicide 6 Could not by determined	28e. Place of Injury - At Tome building, etc. (Specify)	o, farm, street, factory, office		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number.
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the best of my knowler niner: On the basis of examination and manner stated.	dge, death occurred at the till and/or investigation, in my	ime, date and place, opinion, death occur	and due to the causei	(s) and manner as stated
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			30. Name and address of person who I YESATTA MASSAQ	VOI DEPARTME	Da) (Type, Print)	NE, John	NOETH WOL	NUARY 22, 2004 FE STREET DSPITAL, BALTIMORE
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	The Man Man Man Man Man Man Man Man Man Man	Society 1		

			1 - For State Registrar	State of Maryland	d / Department <i>Certificate</i>		Mental Hygien	Even Bud Sud 1995	02377
	· ·		1. Decedent's Name (First, Middle, Last,)			2. Date of Death		3. Time of Death
	Physici /Medio		NATHAN	IEL VOH	NSON		Januan		443M
	Examir	er	4a. Facility Name (If not institution, give	- B-1	4b. City, To	own, or Location of Deat	. (c. County of Death	
			5. Social Security Number 6. Se	x 7. Age (In yrs. I	ast birthday) If Under 1	Year I If Under 24 Hrs	, ,	BALTINE	ene
	Funeral Director			ÂM 2DF 32"		Days Hours Min.		9. Birtholi	/ /
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	death with the Maryland ima 23a or 28a-f show f must be mulfilled at	_	10a. State 10b. County	10c. City	, Town or Location			10	d. Inside City Limits
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0	ding Phy th. After this funeral o	ion	1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury M	Injury at Work?	28d. Describe how inju	ry occurred	
Division of	r Attendi er death. rector: A by the fu	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hon		1 ☐ Yes 2 ☐ No	28f. Location (Street ar	nd Number or Pural I	Pouto Number
<u>S</u>	after after Dire	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	io, iaini, silosi, radiojy, d	illos	City or Town, State	s)	oute reamber,
	ospital or hours aft uneral Dir y filled in		29a. Certifier 1 Certifying Phys	sician: To the best of my know	ledge, death occurred at	the time, date and place	, and due to the cause(s) and manner as stat	ed.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examination)	ner: On the basis of examination and manner stated.	on and/or investigation, in	my opinion, death occu-	rred at the time, date and	d place, and due to the	ne cause(s)
	To t Withi To t	Σ	29b. Signature and title of certifier	1		icense number		te signed (Month, Da	
b .			- UX	may n	a) I	14502	VANO	uny 20	, 2004
	3		30. Name and address of person who co		23a) (Type, Print)	Nonth	JANG TOUN HOS	pick	GENTER
			OR (ANDO Bo		my)	RANDA113	town u	estregland	21/33
	Sta Registra		JAN 3 0 2004	32. Registrar's Signatu	Sparks			,	

JACQUELINE JENNINGS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(HV	Μ		State of Maryland / Der 1 - State Unpend Item #23a,27,28a-f per me G828	partment of	Health f Death	and Menta	l Hygie	ene 2 0 0	4 02378
			Decedent's Name (First, Middle, Last)				e of Death	Day Ye	3. Time of Death
	Physicia /Medic		Jacqueline Jennings				UARY	20, 2004	M
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town,	, or Location	of Death		4c. County of D	Peath
	ДЪ		2114 SAYAN CT		LE HIL	= - 11 7	(D) (I		GEORGES CO
9	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ₺ F 7. Age (In yrs. last birthda, Yrs.	/) If Under 1 Yea Months Day		Min /Mo	e of Birth nth, Day, 1	(ear)	Birthplace (State or Foreign Country) Ashington DC
	Director		579-94-7529 40 Trs. Usual Residence of Decedent			341	y 13,	1903 W	isnington bo
	yland	1	10a. State 10b. County 10c. City, Town or	ocation					10d. Inside City Limits
	a-1-e	ctor	MD Prince Georges Temp	le Hills					tX□Yes 2□No
	or 28	Oire	10e. Street and Number	10f. Zip Code			10	g. Citizen of What	
	s 23e	rai	2114 Sayan Court		0748		N-	U.S.A	American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28a-f show eny injury or other traumatic event. The Medical Examinar must be notified at once.	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☐ Married	If Yes, specify Cu	uban, Mexica	Prigin? (Specify Ye an, Puerto Rican, € y:	s or No- etc.)		White, etc. Black
5-0036	hour tural	ed b		edent's Usual Occ	upation		1 10	6b. Kind of Busine	ess/Industry
5	in 72 n "na Nedis	Completed	(Specify only highest grade completed) (Gir	e kind of work don DO NOT use reti	ne durina mo	ost of working			
2121	d with giene. r the	HO	Elementary/Secondary (0-12) College (1-4or 5+) 3 Cor	rection	Office	er	I	OC Dept	of Correction
פ	e filed al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)			her's Name (First,			
Jai	Ments Ments arked	10	Unobtainable		E	Earlie M.	Jenr	nings	
Maryland	2 sho and is mu		, , , , , , , , , , , , , , , , , , , ,			ber or Rural Route			e, Zip Code)
	s 1 and 2 of Health a Itam 27 is other trau				ourt 1	Cemple Hi	-	1d 20/48 Dc. Location - City	or Town State
0	ges 1 If of P If Its or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other p					
Baltimore,	rtmer rtmer rtant					Fort Lin	-		, Maryland
Ba	Depared Important Importan		The state of the s	401 Blad	ensbu	rg Road I	rent	wood MD	
8760,	Physician /Medical Examiner Medical	ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	Intoxicati	on				Onset and Death
.O. Box 68	death certific e attending p id for use as	Physician/Medical		☐Ectopic pregnar				23d. Date of Month	delivery Day Year
s, P	es ign be	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause (given in Part	11. 23			e to the cause of death? Probably 4 Unknown
Record	The law requii ste has been s bage 2 should	Completed				24:	a. Was an autopsy performe	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Vital		Bec	25. Was case referred to medical		26. Plac	ce of Death (Chec			
	Physician: this certific ral director,	To	examiner? 1 X es 2 No Hospital: 1 Inpatient 2 EP/Outpat	ent 3 DOA	Other: 4 🗆 N	Nursing Home 5	Residen	ce 6 10 Other (Specify) SCENE
on of	ding h. After fune		27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation Tound 2.1 Accident	W	luryat Vork? ⊡Yes 2.25	διΝο		v injury occurred	
Division	or Attending after death. Director: After in by the fune	ertification;	2 Accident 3 Suicide 4 Homicide 2 Recorded not be determined 5 Recorded not be determined 2 Recorded not be determined 2 Recorded not be determined	1777		Unk	nown ation (Stre	et and Number o	Rural Route Number, Sayan Court
Ö	ital or A irs after rat Directled in by	O	Found at Residence					s, Marylar	4
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the investigation, in my	time, date a y opinion, de	and place, and due eath occurred at th	to the cau e time, dat	use(s) and manne e and place, and	r as stated. due to the cause(s)
	To the I within 2 To the complet	Me	29b. Signature and title of certifier	29c. Lice	nse number		290	d. Date signed (M	onth, Day, Year)
LY		10	La feilla Tr	0 0	СМЕ		J	ANUARY 2	1, 2004
ノン	n 8	2	30. Name and address of person who completed cause of death (Item 23a) (Type 27) Completed Cause of death (Item 23a) (Type 27)		Penn	Street,	Balti	more, Ma	ryland 21201
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 3 0 2004	& Sp.	als				

M			1- For UNPEND Item#23a,27,28a-1, Fer ME,6828,2713/14eg Certificate of D	ealth and Ment eath	tal Hygiene Reg. No.		2379
	Physici	an	1. Decedent's Name (First, Middle, Last)	N	ate of Death fonth Day ANUARY 2!	/ Year	me of Death : 40 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L			County of Death	140 1
				RE CITY	ate of Birth	9. Birthplace (S	tate or Foreign
	Funeral Director			Hours Min. FA	ate of Birth Month, Day, Year)	960 Maryl	and
)	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Insi	de City Limits
	se-f sh	Director	Maryland N/A Baltimore				∫Yes 2□No
	within 72 hours after death with the Maryland ene. than 'naturel', or items 23a or 28e-f show ta Moulcel Examiran Le notified at		2502 Mc Henry C+	23	10g. Citi	izen of What Country?	
	or death	Funerai		panic Origin? (Specify) Mexican, Puerto Rican		14. Race - American India Black, White, etc.	an,
5-0036	ours after	Ď	1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No If Yes, Give 1 □ Yes 2 ▼ No Year or Dates:	Specify:		Specify: Blac	K
15-0	n 72 ho "natur edical	leted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupati (Give kind of work done dui life. DO NOT use netired)	on ring most of working	16b. Ki	ind of Business/Industry	
2121	giene. grinner. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Cerical			nporary !	Services
and	d be filed intal Hygir ad other	Be	To The The The The The The The The The The	8. Mother's Name (Firs	st, Middle, Maiden	Sulmame)	
Maryland	2 should and Men Is marks aumatic	To	19a. Informant's Name/Relationship (Type, Print) (nephew) 19b. Mailing Address (Street an	d Number or Rural Rou	ite Number, City o	r Town, State, Zip Code)	
-	1 and 2 Health em 27 ther tra	1	Elder Allen Thomas 1138 Clevel 20a. Method of Disposition (Name of	and St.	Balt	cation - City or Town, Sta	$\frac{230}{230}$
Baltimore	Pages nent of nnt: If It ury or o		1 Burial 2 Cremation 3 Removal from State Cometery, crematory or other place) Cometery, crematory or other place)	2/3/20	04 Du	undalk	Md.
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or items 23a or 28e-1 show any injury or other traumatic event, It a Medical Exacilities In any injury or other traumatic event, It a Medical Exacilities It once.		21. Signature of Funeral Service Licensee 22. Name and Address JoSeph 27.22 W. Nig	Russ FL	neral	Home Md. 2121	6
9(Ì	23a. Part of ther the disease, or complications that caused the death. Do not enter the mode of dying, shock or heart failure. List only one cause on each line.	such as cardiac or resp	piratory arrest,	Interva	ximate al Between and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Narcotic Intoxication Due to (or as a consequence of):				
A	Examiner	_					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Disease) of injury that initiated events c.				
60,	cate be executed obysician and the burial-transit	I Exa	resulting in death) Last Due to (or as a consequence of):				
68760	ificate I g physi as the t	ledical	d				
Box	that the death certificate be exed by the attending physician detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ↓ □ Female 2 □ Female 3 □ Ectopic pregnancy ↑ □ Female 3 □ Ectopic pregnancy ↑ □ Pregnant at time of death 5 □ Other (specify)		2	23d. Date of delivery Month Day	Year
P.O.	t the de by the i	hysic	1 Yes 2 No 9 Unknown				
	Se Ba	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	23e. Did tobacco u 1 ☐ Yes 2[use contribute to the caus	e of death? 4 □Unknown
of Vital Records,	e law requir has been si te 2 should i	Completed		2	24a. Was an autopsy	24b. Were autopsy find prior to completion	tings available n of cause of
al B		e Con	25. Was case referred to medical		performed? Yes 2 No	death? 1 ☐ Yes 2 ☐ No)
f Vii	Physicien: this certific ral director,	To Be	axaminer? 1 Types 2 No Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA Other	26. Place of Death (Che 4 ☐ Nursing Home		6 □Other (Specify)	
o uo	Jing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Daybard Injury Ound Work? 1/25/04 28b. Time of Death Injury (Month, Daybard 4:10 pM 1 PM	at 28d. [es 2. 25 No U	Describe how injur nknown	y occurred	
Division	or Attendi after death. Director: A ın by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at residence		City or Town, State		
_	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	, date and place, and d	ue to the cause(s)		
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License r			te signed (Month, Day, Ye	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			UARY 26, 200	
_			ZABILLAG AU III Per	on Street, Ba	ltimore,	Maryland 2	1201
	Sta Regista		31. Date filed (Month, Day, Year) 1AN 3 0 2004 32. Registrar's Signature Aparthal				

			1 - For Amend Item#19bpo	State of Per (INFG828	Marylan 2/2/20	d/Depa XV4 EW Cer	rtmen tificate	t of H	ealth a	and M			200	
			1. Decedent's Name (First, Middle, Last)							2. Date of De Month		Yea	3. Time of Death
	hysici: /Medic		James T. Krebs								Januar	су 19	, 2004	4 11:20 AM
	xamin		4a. Facility Name (If not institution, give		er)		4b. City,	Town, or	Location of	of Death			County of D	
			Gilchrist Cente					OWSOI		0411-			Balti	
	neral ector		212-30-0066	x 7.]M 2□F	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month Da OCT 14	y Year)	32 M	Birthplace (State or Foreign Country) Iaryland
pui	*		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town or Lo	cation							10d. Inside City Limits
aryla	sho	5		imore	Ì	То	wson							1 ☐ Yes 2 ☑ No
Pe N	-88-1	ect	10e. Street and Number	THIOLE			10f. Zip	Code				10a Citiz	en of What	
death with the Maryland	Legin	ä	6601 N. Charles	Street				2120	4				USA	
ath	s 23	Fra		12. Was Decede	nt Ever in II	S 13 V				gin? (Sp	ecify Yes or No	n- 1		merican Indian,
0	or item	by Funeral Director	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	Armed Force 1 X Yes 2 If Yes, Give Year or Date	s? ⊒ No	1	f Yes, spec	offy Cubar	Specify:	i, Puerto	Rican, etc.)			/hite, etc.
Dour J	al Ex				s. JI-J	16a, Deced	tent's Heus	al Occupa	ition				nd of Busine	7-4-4
Z I Z I S-UUSO d within 72 hours af giene.	nation and	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		(Give	kind of wor	rk done d	uring mos	t of work	ing	100.10	ig of Busino	oss/industry unk
Ne Ather	nedi M	E C	Elementary/Secondary (0-12)	College (1-4	or 5+)									
and 2121 be filed within ntat Hygiene.	nt, ii		17. Father's Name (First, Middle, Last)					fore		er's Nam	e (First, Middle	, Maiden :	Sumame)	
VIANG ould be file Mental Hy	o pe	Be	John Adam Krel	10						A ana	s Taylo	r		
ould Me	nark	ဥ	19a. Informant's Name/Relationship (T)			19h Mailie	Address	(Street a					Town State	e Zin Code)
Mar d 2 sh th and	7 is r		Gloria Krebs/s			10	Chape	Tov	ine Ci	rcle	a <i>l Route Numb</i> le Nott	inoh	am MT	21236
t and Healt	ther the		20a. Method of Disposition		20b. F	Place of Dispo	1000			and the state of t	Date			or Town, State
or sign	= 0 = 0		1 Burial 2 Cremation 3 D		ite	cemetery, cren	natory or o	ther place	9)					
TIT t. Pe	rtant		'4 Donation 5 Other (Specify)		<u> </u>	22	Name an	d Addros	e of Eacilit	h,				
Baltimore, permit. Pages 1 a Department of Hee	any ir		21. Signalure of Europeal Service Licens	///	uce	\subset B	altin	nore,	MD	212	01		ltimoı	re Street
Phys	sician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition		sed the deat h line.		er the mod	e of dying	g, such as	cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	edical miner		resulting in death)	Due to (or	as a conseq	quence of):			***					
cuted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or	as a consec	uenca of):								
/6U, te be executed	physician and s the burial-transit	cal Ex	resulting in death) Last	Due to (or	as a conseq	quence of):								
oertifical	as th	ledi						-				T		
BOX ath cer	esn nse	S	23b. was decedent pregnant	23c. If yes, outcom			Ectopic pr	eonancv				2	3d. Date of	
C. BC	ed by the attending phi detached for use as th	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnan 9☐ Unknow	t at time of c		Other (sp						Month	Day Year
ords, P.O	been signed b should be deta	by Pt	Part II. Other significant conditions co	ntributing to deat	h but not res	sulting in the u	nderlying c	ause give	n in Part I		23e. Did 1	tobacco us	se contribute	e to the cause of death?
d S	n sign										1,83	Ŷes 2[]No 3□	Probably 4 Unknown
() >	shou	lete									24a. Was	an	24b. Were	autopsy findings available
କ୍ର ଅ	has Je 2	ompleted										ormed?	prior death	
		ပိ	25. Was case referred to medical						26 Place	e of Deat	1 ☐ Yes	2, No		765 21110
		o B	examiner?	Hospital:	ationt 2] ER/Outpatien	t 3 🗆 DC	Othe			me 5 Resi	1000	Mother (S	Specify) Hospice
	r this arai di	-	27. Manner of Death	28a. Date of	njury	28b. Time of	-	8c. Injury Work		-	28d. Describe		1.4	poony, 110 /
6 를 급	After	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	М		res 2 🗍	No				
DIVISION for Attending after death.	octor:	fica	3 ☐ Suicide 6 ☐ Could not be	286. Place of	Injury - At h	ome, farm, str	eet, factory	, office	1.00					Rural Route Number,
DIVISION Attend	d in b	Certification:	4 Homicide	building	, etc. (Specil	(y)					City or 10	wn, State)		
Lothe Hospital within 24 hours a	To the Funeral Dli completely filled in	edical C	29a. Certifier Check only one) Certifying Phy	rsician: To the be iner: On the basi and manner	s of examina	owledge, death ation and/or inv	n occurred vestigation	at the tim , in my op	ie, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner place, and o	r as stated. due to the cause(s)
o the	o the	Me	29b. Signature and title of certifier	1.0			290	. License	number			29d. Date	signed (Mo	onth, Day, Year)
<u>-</u> ₹	⊢ ŏ		M thathen	y Kiles	, cu	Δ	1	125	20.	ر ک		Jane	UNY	19,2004
	8		30. Name and address of person who	moleted and	of death (Ites	m 23a) (Tune	Print)	, , , ,				2/41	-11.	, ,
	10			BMC 67	01 N.	Charle	-St.	Bal	Ho.	md	2(20)	بح		
	Sta	ate	31. Date filed (Month, Day, Year)	32 Reg	istrar's Signa									
	ى Regist		JAN 3 0 200	14	year A	F An	ander							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Berenice 01 Kempler 16 / 04 5:00pm /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Chevy Chase Montgomery 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Hours 1□ M 2🖵 F 317-05-8385 95 2/19/1908 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or have not any injury or other traumath 10a. Stete 10b. County 10c. City, Town or Locetion 10d. Inside City Limits MD Montgomery Chevy Chase 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8700 Jones Mill Road 20815 USA by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZCNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: White 3€34Vidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 0 Secretary Unk. ' 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nathan Weinstein Sadie Glassman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Kempler / Son 6708 Post Rd., Fort Wayne IN 46814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🛱 Removal from State Hebrew Orthodox CemeteryJanuary 19, 2004 Mishawaka, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** SEPSIS SYNDROME Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed inding physician and usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? COMFORT CARE DEMENTA, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2000 10 765 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? i Director: After the in by the funers 28b. Time of 28d. Describe how injury occurred edicai Certification: 5 Pending investigation 1 Natural r death. 1 ☐ Yes 2 ☐ No 2 C Accident 6 Could not be 3 C Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide To the Hospital JECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 53367 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print), GAITHERS BURG, MD: 20878. 31. Date filed (Month, Day, Year)
JAN 3 0 2004 32, Registrer's Signature State Registrar

DHMH 16 Rev 6/95

			State of Marylar	Certificate of De	ath	Glerie Z U U IA	02382
	Physician	Decedent's Name (First, Middle, La MARGARET	B.	KERSHAW	2. Date of Dea Month JAN	23 100 Year	3. Time of Death 08:10
	/Medical Examiner	4a Facility Name (If not institution, giv	e street and number)	4b. C	ity, Town, or Location of Death	4c. County of Death	1
		NORTH ARUNDEL H	OSPITAL	GLE	EN BURNIE	ANNE ARUND	
	Funeral Director	5. Social Security Number 5.78-01-3147 6. S	ex		Jnder 24 Hrs. 8. Date of Birt ours Min. MAY 23	y 1915 9. Birth	place (State or Foreign LINGTON D.C.
_	pu s	Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Location		1	0d. Inside City Limits
	e Maryler Sa-f show Alfried at	MD ANNE ARU		CROFTON			1 ☐ Yes 2 🙀 No
	offer deeth with the Marylend with the Marylend with terms 23a or 28a-f show niner must be notified at Funeral Director	10e. Street and Number 2424 HYANNIS LA	NE	10f. Zip Code 21144		10g. Citizen of What Cour	itry?
020	5 2 2 5	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 257 No If Yes, Give Year or Dates:	1□ Yes 2 No Sp	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) pecify:	14. Race - Americ Black, White, Specify: WHI	etc.
Maryland 21215-0020	be filed within 72 ho tal Hygiene. d other than "natura event, the Medical. Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation (de completed) College (1-4or 5+)	16e. Decedent's Usual Occupetion (Give kind of work done during life. DO NOT use retired) BINDERY WORKER	g most of working	GOV T PRI	-
2	filed the CO and the C	17. Father's Name (First, Middle, Last)		18.	Mother's Name (First, Middle,	Maiden Surname)	
<u> </u>	Mental Mental Mental Britic ev	John Bacigalupi			Catherine Smit	h	
2	shou and M and M	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and I			Code)
	end 2 salth e	MARILYN HARDING	DAUGHTER	2424 HYANNIS LA	NE CROFTON, MD		
544wl Baltimore	Peges 1 nent of He ant: If Ren ury or oth	20a. Method of Disposition 1 ☐ Burial 2万 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State ME	Place of Disposition (Name of temptery, crematory or other place) TRO CREMATORY	Date 1-27-04	20c. Location - City or To	
デR5件Au ■ Baltim	permit. Deperti Importi any Inj pnce.	21. Signature of Funesal Service Licer	isee	22. Name and Address of HARDESTY FU	NERAL HOME P.A	A. 12 RIDGEL ANNAPOLIS,MD	
U		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h. Do not enter the mode of dying, su			Approximate Interval Between Onset and Death
* C	Physician /Medical Examiner	Immediate Cause (Final disease or condition	STROKE Due to (Sylars
L	_	resulting in death)	Due to (c	r as a consequence of):			54001
777	ifficete be executed g physician end es the buriel-transit	Sequentially list conditions.	0.	r as a consequence of):			7 (- 1.)
-R GARE	e exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events				į	
R GA	sete b shysic the b	that initiated events resulting in death) Last	Due to (c	r as a consequence of):			
A. 8. 8. 8. 8. 8. 8. 8. 8. 8. 8. 8. 8. 8.	entific ding p		d			į.	
MA	atten for u						
C	the du y the oched	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying cause given in	Part I. 23b. Did t	obacco use contribute to res 2 ☑ No 3 ☐ Pro	bably 4 Unknown
<u>a</u>	s that gned b e dete					res ziprio 3 Fio	Jably 4 Olikilowii
Division of Vital Becords. P.O.	Attanding Physician: The law requires that the death certificate be executed rotesth. scion: After this certificate has been signed by the attending physician entry the funeral director, page 2 should be deteched for use es the buriel-transification: To Be Completed by Physician/Medical Exemi				24a. Was perfor	med? av	ere eutopsy findings ailable prior to mpletion of cause death?
ă	The la				101	es 2 No 1	∃Yes 2 ⊘No
<u> </u>	triffice	25. Was case referred to medical		26.	Place of Death (Check only o	ne)	
>	nysici nis ce I direc	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 €		Nursing Home 5 ☐ Resid		y)
ion	nding Prath. r: After the tunera	27. Manner of Death 1 ②Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury at Work? M 28c. Injury at Work? 1 ☐ Yes	28d. Describe h	ow injury occurred	
Divio	s effer de	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory, office	28f. Location (S City or Ton	Street and Number or Rura m, State)	il Route Number,
*	To the Hospital or Attanding Physician: The law requires that the death certification of the Hospital or Attanding Physician: The law requires that the death certificate to the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deteched for use expensively the following the funeral director. To Be Completed by Physician/Met	29a. Certifier 1 1 Certifying Ph (Check only one)	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death occurred at the time, d tion end/or investigation, in my opinio	ate end place, and due to the on, death occurred at the time, o	cause(s) and manner as s date and place, and due to	tated. the cause(s)
ì	To the comple	29b. Signature and title of certifier	1	29c. License nui	mber	29d. Date signed (Month,	Day, Year)
		Valua Si	rall an	0200)47	61/25/04	f
	8	Elliott Gorb at	completed cause of death (Iter	Madism Pari	t Inve, 61	en Burnie,	md, 21066
	State Registrar	31. Date filed (Month, Day, Year) JAN 3 0 2004	32. Registrar's Sign	Sparks'	`	(

		1	For State Registrar	rica	3	•			-		t of H	lealth a	and M	lental Hy	Reg. No	6 U	04	023	383
	Dhysiair		1. Decedent's Name			.,								2. Date of De Month	Da	у_	Year	3. Time of I	_
	Physicia /Medic	al	EVELYN E							I		A	15 1	SANUA	_	. County	2004	12:42	PM
	Examin	er	4a. Facility Name (II							_	TOWN, OI	Location	of Death			,		ah la	
			ST. AG 5. Social Security N		4 <i>E Pd</i> 6. Sex	LTH C			st birthday)	If Under	1 Year			8. Date of Bir (Month, Da			plica 9. Birthp	lace (State or etry)	Foreign
	Funeral Director		214-05-34			4 2 ⊠ F		94	Yrs.	Months	Days	Hours	Min.	Dec. 1	ay, Year) 3 . 19	09	Coun [Mary]	land	
			Usual Residence of	Decedent									1						1.1.11
	arylan ahow	_	10a. State	10b. County					, Town or Le									0d. Inside City	•
	8a-f.	Q L	Maryland	Baltin	nore	-		C	Catons	ville 10f. Zip					10a Cit	lizon of V	Vhat Cour		
	with ti		10e. Street and Nur								altin	no**			_		State	•	
	eath	erai	3320 Ber	ison Av		. Was Dec	edent E	ever in U.S	S. 13.				igin? (Sp	ecify Yes or No Rican, etc.)		14. Race	e - Americ	an Indian,	
10	r iten	Funerai	1 Never Marri	ied 2⊟ Marni	1	Armed F 1 ☐ Yes	orces? 2 ♣ N							Rican, etc.)			k, White,		
030	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or liems 23a or 28a-f ahow is marked other than "natural", or liems 23a or 28a-f ahow reumatic event, the Macuical Examiner must be notilized at	þ	3 XWidowed	4 Divorced		If Yes, G Year or [ve Dates:			1 🗆 Yes	263 NO	<i>эрөспу</i>				Specify	" Wh:	ite	
5-0	72 h	Completed	(Spec	15. Decedent	s Educa t grade d	ition completed,)		(Give	dent's Usu	rk done i	during mos	st of work	ring	16b. K	lind of Bu	isiness/In	dustry	
121	vithin ne. hen	mpl	Elementary/Seco	ondary (0-12)		College	(1-4or 5	+)		<i>во мот ш</i> Ly Mal		3)				Candy	Com	pany	
12	filed v Hygie other t		17. Father's Name	(First, Middle, I	ast)				- Carre			18. Moth	er's Nam	e (First, Middle				<u> </u>	
an	d be ental ced o	To Be	Louis (Em	ma G	oodmuth					
Ž	shout nd Me marl	Ε,	19a. Informant's Na		ip (Type	, Print)			19b. Maili	ng Address	(Street			al Route Numb		or Town,	State, Zip	Code)	
Z	and 2 ealth a m 27 is		Bever1y	Wharto	n-Da	aught	er		116 7	errap	oin l	Lane,	Ste	vensvil	le,	Mary	land	21666	
Baltimore, Maryland 21215-0036	-I ==	V 4	20a. Method of Disp		2 O D	naval from	Ctata	20b. Pla	ace of Dispermetery, cre	osition (Na matory or c	me of other plac	ce)		Date	20c. L	ocation -	City or To	own, State	
Ē	Pages nent of ant: If it ury or o		* 4 □ Donation	5 Other (Sp	ecify)		Jiale	ватт	metery, cre imore Lou	don P	ark ark	ry e	Jan.	17, 04	Ba1	timo	re, l	Marylar	ıd
alt	permit. Departr Importa any inj		21. Signature of F	ineral Service	icensed	11/	210	1		2. Name ar oudon	nd Addre Par	ss of Facil	ity nera]	l Home					
(III	20599		1/4	ax.	X	apl	104	ion	3	620 W	ilke	ns Ay	renue	Balt		e, M	aryla	and 212 Approximate	
_ 1	*		23a. art1. Enter t shock, or hea		only of										11165(,			Interval Betw Onset and D	veen Jeath
	Physician /Medical		Immediate Cause disease or condition resulting in death)	วก	_ a.				TESTI	NAL	H	EMOR	RHA	GE.				3 DAYS	> ,
	Examiner				ſ	Due to	(or as a	a consequ	ience of):										
	(W	-e	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate	Ь.	Due to	o (or as a	a consequ	ence of):										
	outed Id ransit	Examiner	that initiated events	5	c.														
760,	e be executed sician and buriat-transit	Exc	resulting in death)	Last		Due to	oras a	a consequ	ience of):										
876	9 7 0	lical			d.														
Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certificat. this certificate has been signed by the attending phy ral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:		234	c. If yes, o	utcome	of pregnar	ncv							23d Dat	te of delive	201	
Во	attend for us	ian	23b. Was deceden	months?	2.50	1 Live	birth	2 Fetal	death 3	□Ectopic p		У				Mo			'ear
_0	the de y the ched	ysic	1 ☐ Yes 2 i 9 ☐ Unknown			9□ Unk													
Za.	w requires that the death been signed by the atte should be detached for	y Pt	Part II. Other signi	ficant condition	ns conti	ributing to	death bu	ut not resu	ulting in the	underlying	cause giv	en in Part	I.	23e. Did	tobacco	use cont	ribute to t	he cause of de	eath?
78	quires in sign	q pe	COLO	ONIC C	A.			DIVE	r ticul	1715				1 🗆	Yes 2	□No	3 🗌 Prot	bably 4 🖼	nknowπ
200	aw reis bee	plet	ABBO	MINAL	Ac	RYIC	A	NEUR	MZYSM	REPI	MAR			24a. Was		24b. \	Were auto	psy findings a	available
1	sician: The law certificate has t lirector, page 2 s	E O	MITE	PAL V	ALVE	- P	ROLL	APSE						perf	ormed?	5	death?		
ita	artifica ctor.	Be	25. Was case references											th (Check only					
\mathcal{L}	Physic this ce al dire	2	1 ☐ Yes 2 €		Ho				ER/Outpatie				lursing He	ome 5 Res				(y)	
Su C	ending P eath. or: After I he funera	iuo ::	27. Manner of Dear	5 Pendin		28a. Date (Mo	nth, Day	y Year)	28b. Time (Injury	M	28c. Injui Woi	ryat rk? ∣Yes 2.[7No	28d. Describe	now inju	iry occuri	ea		
Sis	death ctor: y the	icat	2 Accident 3 Suicide	investig 6 □ Could i determ	not be	28e. Plac	ce of Inju	ury - At ho	me, farm, s				3.10	28f. Location			er or Rura	al Route Numi	ber,
£ S	after after Dire	Certification:	4 Homicide	цөкөпп	IIIeu	buil	ding, etc	c. (Specify	()		,			City or To	own, Stat	e)			
X	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier	10 Certifyin	g Physi	cien: To th	he best	of my know	wledge, dea	th occurred	at the ti	me, date a	ind place	, and due to the	cause(s	s) and ma	nner as s	tated.	
X	he Ho in 24 he Fu pletel	Medicai	(Check only one)	2 Medicei	Examine	and ma	inner sta	ted.	don and/or i					rred at the time					
	To the within 2 To the complete	Σ	29b. Signature and	d title of certifie	r				Ministr	22, 29		se number		1				Day, Year)	
				TAZA					1 WWW	0	r	-176	10		JAN	UAR'	y (5	, 2004	<u> </u>
			30. Name and add		e.							3AL711	airo C	MO.	7139	19			
	Sta	oto.	31. Date filed (Mor		gv.i			ar's Signal	TON &	VENUE	= , t	JAK-[1]	IVIGINE E	: 140,	~2	-7.			
	Registr			N 3 0 20	004	Land	ter	B	dos	de									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 7, James R. Knauss January 2004 5:50 PM /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 502 N. Market Street Frederick Frederick 8. Date of Birth (Month, Day, Year Jan 17, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State of Foreign Country) 5. Socief Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**]M 2□F 71 Yrs. Director 053-26-5699 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene any pinchant: If item 27 is marked other than "natural", or items 23a or 28a-if show any injury or other traumatic event, I'm Medical Examinations to any place. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Frederick Frederick 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 N. Market Street 21701 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 unk 1 ☐ Yes 2 🌠 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Larry West/FI 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) in State 21. Signature of Funeral Service Licensee Ronal d S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Enter the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Ihrost **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as attending p IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown þ signed b Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signated the 12K Yes 2 □ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e page certificate To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No After this of Yes Certification: To 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 🗌 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D3516 nuary 20,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) With NMIL afre 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 3 0 2004 Registrar

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment rtificate			ınd M		ene 2 (004	02385	
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Deati Month	Day	Year	3. Time of Death	
Van P	/Medi	cal	Etta Marie Lewis				-		/ D Ab	January	1		10:40 A M	
	Examir	ıer	4a. Facility Name (If not institution, give str 1520 North Avenue,								4c. Count	y of Death		
. 2	Funeral	/	Social Security Number 6. Sex		(In yrs. last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign	
Y,	Director		215-22-7223 1 I	2 % F	80 Yrs.	Months Days Hours Min. (Month, Day, Ye Sep 22,					1923	(ear) Country)		
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation							0d, Inside City Limits	
	Aaryla f sho	ō	MD N/A		Baltimor								1 Nes 2 No	
	28a-	Director	10e. Street and Number		Datermor	10f. Zip	Code			10	g. Citizen of	What Cour	ntry?	
	h with		1520 North Avenue,	Apt. 608		212	17				United	Stat	es	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ite Medical Eventical maintain and once.	by Funerai	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ex Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deced f Yes, spec	ify Cuban	panic Orig , Mexican Specify:	in? (Spe , Puerto f	cify Yes or No- Rican, etc.)			etc.	
ð	2 hou	ted	15. Decedent's Educa	ion	16a. Dece	dent's Usua	I Occupat	ion		1	6b. Kind of B	Blac dusiness/Inc		
21215	d within 7 giene. or than "n	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	om <i>pleted)</i> College (1-4or 5+	life	kind of wor DO NOT us Stic	rk done du se retired)	iring most	of workir	ng	Privat	e Res	idences	
Maryland 21215-0036	uld be file Mental Hy irked oth	To Be (17. Father's Name (First, Middle, Last) James Lewis					18. Mother Emma		(First, Middle, M	laiden Sumar	ne)		
dan	2 sho and l is ma		19a. Informant's Name/Relationship (Type	,		-				Route Number,			*	
e,	1 and 1ealth am 27 thar to	1	Ms. Geraldin Lewis 20a. Method of Disposition	Smith/Co	OUSIN 3903 20b. Place of Dispo			er Ro			ce, MD			
Baltimore,	ages nt of h t: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Ren	oval from State	cemetery, crer	natory or ot	her place	1	J	an 31		-		
Ħ	artme ortan injuri	li	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service, Licensee 	1 4 Al mi	Chesapea	. Name and	d Address	of Facility	,		Beltsv.		MD	
Ã	Depa Impo any is		> Sk_ Nule	Mo	0986	Crema 8717	tion Gree	and n Pas	Fune	eral Alte	ernati Balt	ves	, MD	
8760,	cate be executed / Medical bhysician and physician and the burial-transit the burial-transit	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to anni equate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.		consequence of): consequence of):	itro	<i>DY1.1</i>		11/19		cerry		nours	
P.O. Box 68	The law requires that the death certificate be executed tile has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pre						te of delive	ny Day Year	
rds, P	quires that n signed b uld be deta	ed by PI	Part II. Other significant conditions control EmphySema	outing to death but	not resulting in the ur	nderlying ca	use giver	in Part I.			acco use cont 2 □ No		e cause of death?	
Vital Records,	Physician: The law re this certificate has bee ral director, page 2 sho	Completed by	Peripheral vaso Dealmeratura	ular i	disease + disea	e se				24a. Was an autopsy perform	ed?	prior to con death?	osy findings available inpletion of cause of	
Ĭ.	Attanding Physician: The death. ector: After this certificate by the funeral director, pag	Be	25. Was ase referred to medical examiner?	pital:	W		Other			Check onl one				
ō	ding Phys .r After this funeral di	1: To	1 ☐ Yes 2 No Hos 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ☐ ER/Outpatien 28b. Time of		A	4 Nur		ne 5 Resider 8d. Describe hov			")	
0	nding th: : Afte e fune	ition	1- Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day')	rear) Injury	М	3c. Injury a Work? 1 □ Ye	s 2 □ N			injuly occur			
Division of	al or Attandi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory,	, office		2	8f. Location (Stre City or Town,		er or Rurai	Route Number,	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) 1 Certifying Physic 2 Medicel Examine	an: To the best of On the basis of eand manner state	xamination and/or inv	occurred a restigation,	it the time	, date and nion, death	place, a	nd due to the cau d at the time, dat	use(s) and ma e and place,	anner as sta and due to	ated. the cause(s)	
)	To t with. To t	Σ	29b. Signature and title of certifier Level Gardy	nom,	M.D.	29c.	License i	number 580	47		130 · (Day, Year)	
	9		30. Name and address of person who comp	m M.D.	th (Item 23a) (Type 295, Po	Print)	57	Bati	+MI	721201	,			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 3 0	32. Registrary	Signature	Land	1			·				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar 02386 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Grace DeAlice Lapp J<u>anuary</u> 24. 5:15 A /Medical 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1717 Wilson Avenue Baltimore Bar If Under 24 Hrs <u>Baltimore</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Birthplece (State or Foreign Country) Hours Months Davs 1 ☐ M 2 🂢 F Director 62 Yrs. 217-38-3716 Feb. 15, 1941 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show r than "naturel", or items 23a or 28e-f shov the Medical Examinat must be notified at 1 Yes 21 No Baltimore Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1717 Wilson Avenue 21227 Completed by Funeral United States filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygier 27 Is marked other the traumatic event, In School Receptionist Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be ၉ Russell Miller Rozella Carns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 I <u>Melvin Lapp</u> <u> Husband</u> 1717 Wilson Ave., Baltimore, MD 21227 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Meadowridge **4** □ Donation 5 □ Other (Specify) 1-27-2004 Memorial Park

22. Name and Address of FacilitAmbrose Funeral Home, Inc. Elkrid e MD 21. Signature of Funeral Service L 1328 Sulphur Spring Rd., Arbutus, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and doe detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig , page 2 should b 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Vital the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only or examiner? Other: 4 Nursing Home 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 5 Residence 6 Other (Specify) 3 DOA ö 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4. Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 S ACCADDA MATATE 2-1 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 3 0 2004 Gosoff)

Amend Item 29c, dper Dr., G827, 01/30/04dhb Certificate of Death 02387 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician Month 6:45 AM ETHEL LAIBSON ANUAR 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner rlel If Under 24 Hrs. 8 Do If Under 1 Year 5. Sociel Security Number . Age (In yrs. lest birthdey) Date of Birth (Month, Dey, Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Yrs. 239-05-3162 85 Director APR.9,1918 N.C. Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 ☐ No ANNE ARUNDEL SEVERNA PARK 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 355 SOUTH DRIVE 21146 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 ☐ Never Merried 2 X Married Maryland 21215-0020 ò 1 ☐ Yes 2 ☑ No Specify Be Completed by 3 Widowed 4 Divorced WHITE 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OWNER INTERIOR DESIGN 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pe **HECHTER** Peges 1 end 2 should nent of Heelth and Men DANIEL REINA (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 355 SOUTH DRIVE - SEVERNA PARK, MD 21146 Department of Heelth Important: if item 27 GEORGE LAIBSON / HUSBAND or other Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 1/13/04 RANDALLSTOWN, MD 21. Signetyre of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Enjer the disease, or com, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 20mm19 Examiner Due to (or as a consequence of): by Physician/Medical Examiner Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) of Vital Records, P.O. Box 68760. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tyes 2 No cete hes been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has Tu Yes 24 Nu 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: မှ 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 b patient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Diractor: After this 28b. Time of Injury 27. Menner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division or Attanding 1 Naturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled 1 eritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20094 01/29/04 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 3 0 2004 Registrar

		1- State Registrar AMEND ITEM #1	1 Staten, G827, U1/9 9b PER FH G828 2/0	b/ Qana rtment of 6/0 Centificate of	Health and I Death	Reg. No		02388
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Exam		4a. Facility Name (If not institution, give	street and number)	4b. City, Town	or Location of Death	1 4c.	. County of Death	
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Funera		5. Social Security Number 6. Se		st birthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Year)	9. Birthp Cour	place (State or Foreign
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pr ,		Usual Residence of Decedent 10a, State 10b, County	140- Cit.	Town or Location				10d. Inside City Limits
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8a-f	Director	MD NA	Balt	timore				
or 2	Öre	10e. Street and Number		10f. Zip Code		10g. Cit	tizen of What Cour	ntry?
23a	-ia	7321 R. Castler			1244		U.S.A.	
r de	ne	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	 13. Was Decedent of If Yes, specify Cu 	f Hispanic Origin? (S Iban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	 Race - America Black, White, 	
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arylan should be nd Mental marked c	2	William Davis 19a. Informant's Name/Relationship (7	una Print)	19h Mailing Address (Stre	· · · · · · · · · · · · · · · · · · ·		or Town State Zin	Code) · ·
Man d2 s th an 7 is r		Christine J. McSwain		19b. Mailing Address (Stre				
Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mariteal Examinant be indiffied all many injury or other traumatic.		Christine J. Mc	Swaine-Daugi	nter 7321 R ace of Disposition (Name of	. Castle		ocation - City or To	more, Md
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the de	sic	1 Yes 2 No	4□Pregnant at time of dea 9□Unknown	ath 5 ☐ Other (specify)				
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		E.P.W.LL	AMSONE	A.J. D1	1171	Jaw	" OBRY	5, 2004
		30. Name and address of person who	ompleted cause of death (Item	23a) (Type, Print)		<u> </u>		(3, 2004 (AN) (4042
		E. P. Will, AMS.	~=3933 SI	F JOHNSHAM	reELLI	0175 (0,79	MARY	AND (HOYZ
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure A. a. t.		./	/	,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** George Joseph Merkle, Sr. January 2004 11:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 259 Dogwood Road Millersville Anne Arunde1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2□F 63 220-36-0239 Director 5/8/1940 ΜI Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County or 28a-f show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heatih and Mental Hygiene. ant of Heatih and Mental Hygiene ant: If item 27 is marked other than "natural", or Itams 23a or 28e-f show ary or other traumatic event, It is Madical Examiner must be natified at 1 ☐ Yes 2√√√No Funeral Director ANNE ARUNDEL MILLERSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 259 Dogwood Road 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ Specify: White ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROLAND MERKLE 2 AMELIA MESTERHAZY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMELIA PUDERBAUGH - DAUGHTER 112 Bliss Lane, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State permit. Page Department of Important: If sny injury or Bayview Crematory 4 □ Donation 5 □ Other (Specify) 1/28/2004 Baltimore, MD 21. Signature of uneral Service License 22. Name and Address of Facility FINK FUNERAL Kelly Chegory Fink #M01148 426 CRAIN HWY., S, GLEN BURNI 23a. Part | Enter the disease, examplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061 Approximate Interval Between Immediate dause (Final METASTAS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 2 No 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 27. Manner of Death 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29ch License number 29d. Date signed (Month, Day, Year) 30. Nam 31. Date filed (Month, Day, Year 32. Registrar's State 200 3

DHMH 17 Rev 1/2001

Registrar

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Maryland 21215-0036	hour		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupati	on	16	b. Kind of Business/I	Industry
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Box	he death certi the attending ched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			very Day Year	
P.0	that the the the the the the the the the th		Part II. Other significant conditions co	ntributing to death but n	not resulting in the u	nderlying cause given	in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ds,	uires sign	d by						1 🗆 Yes	2 No 3 Pro	obably 4 DUnknown
of Vital Record	w req	Completed						24a. Was an	24b. Were au	topsy findings available
Re	The la	E O						autopsy performe	d? death?	completion of cause of 2 \(\subseteq \text{No} \)
tal		0	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2ty 1 (Check only one)	10 103	20,10
<u>></u>	8 U D	To B	examiner? 1 Tes 2 No	Hospitaf: 1 Inpatient	2 ER/Outpatie	Other			ce 6 7 Other (Spec	(ify) HOSPICE
	ding After fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Work?		28d. Describe how	injury occurred	- MADE TOIL
Division	or Attendation Director	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined							ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C		rsician: To the best of riner: On the basis of example and manner stated	amination and/or in					
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Month	n, Day, Year)
•	- s - ō			^_		DI	1377		1/77	104
	-		30. Name and address of person who c	ompleted cause of deat	th (Item 23a) (Type.	Print)	, , , , ,	J	1/00	1-7
	3		DR. TARIO MAHMOO			_	ттиоитти	, MD 2109	3	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's		V. 0	VIVI-UI'I-	, 1110 ∠IVY	9	
	Regist	rar	JAN 3 0 2004	grand of	S. A. S. S. S. S. S. S. S. S. S. S. S. S. S.					

8:40 p.m.

JANUARY 21, 2004

HOWARD MUSE

		1 - For State Registrar	State	of Marylar	nd / Depa <i>Cer</i>	artment of F	lealth and l <i>Death</i>		giene? (104	02391
		1. Decedent's Name (First, Midd	e, Last)					2. Date of De	ath	Vane	3. Time of Death
Physic /Medi		Keyyon Makins	:					Januar	y 28, 2	2004	4:20 A M
Exami		4a. Fecility Name (If not institution	•				r Location of Death	1	4c. Coun	ty of Death	
		University of N	Maryland M	Medical	Center					N/	/A
Funeral		5. Social Security Number	6. Sex 1 □ M M 2 □ F	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	v. Year)	Cou	
Director		220-23-0266	10,441 201		14 Yrs.			May 4	, 1989	Mary	länd
and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation	10d. Inside City Limits				
vlany!	ō	MD N/A		Ba.	ltimore					-	1 MYes 2 No
the 288	Director	10e. Street and Number		Da	TCIMOTE	10f. Zip Code			10g. Citizen of	What Cou	ntry?
3a or	0	3428 Spelman R	oad			21225			United		•
ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U		Vas Decedent of H	lispanic Origin? (Si	pecify Yes or No			can Indian,
or fta		1 Never Married 2 Mar	ried 1 ☐ Yes	2 (3 No	11	Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		ack, White,	etc.
ural', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I		1	☐ Yes 2☐No	Specify:		Spec Bla	ify: ack	
72 h	Completed		it's Education st grade completed)	(Give	ent's Usual Occup	during most of wor	kina	16b. Kind of		
ithin ne.	idu	Elementary/Secondary (0-12)	1	(1-4or 5+)	life. L	OO NOT use retired	1)	9	Baltin		
ygier ti		9			Stude	nt			Public		ools
be fife d oth	Be	17. Father's Name (First, Middle,					18. Mother's Nam		, Maiden Suma	me)	
at yielild Z i Z i 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hyglene. It marked other than "natural", or flams 23a or 28e-1 show unatic event, the Medical Exeminar must be notified at	2	Larry Makins,			J			atthews			
Vicility of the month of the mo		19a. Informant's Name/Relations					and Number or Ru				Code)
t and tealth and and and and and and and and and and		Ms. Danielle R 20a. Method of Disposition	obertson-		3428 Place of Dispos		Road, Ba	Ltimore Date	·		
or of the second		1 Purial 2 Cremation			cemetery, crem	natory or other plac	:e)	Feb 2	20c. Location		
mit. Pages partment of portent: If it y injury or of		'4 □Donation 5 □Other (S		M		el Cemete	-	2004	Baltin	ore,	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exemples must be notified an once.		21. Signuture of Funeral Service	. helle	-6	C		William: Baltimo:				
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory as	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Stah	Usu	Is F	Free	k			Onset and Death
/Medical		resulting in death)	Due to	(or as a consec	quence of):			-			
Examiner		Sequentially list conditions	b								
ъ д	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quence of):						
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	,							
Sien sien surrial	Ü	rosuling in doutin cast	Due to	(or as a consec	quence ot):						
icate be executed physicien and sthe burial-transit	dicai		d								
	0	IF FEMALE:	00- 14								
ath c attend	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome of pregn birth 2 ☐ Feta	al death 3 🗌	Ectopic pregnancy				ate of delive	ery Day Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□ Unkr	nant at time of one	death 5∐	Other (specify)					,
hat ti		Part II. Other significant condition	ons contribution to	death but not res	sulting in the un	deriving cause one	en in Part I	23e Did to	obacco use con	tribute to th	ne cause of death?
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	d by	3			Jenning III and an	donying danso give	J. 11 1 4 1 1 .	1 🗆 1		3 Prob	
neeu Houlk	etec								1		
2 8 8	Completed							24a. Was autop	sy	prior to con	psy findings available mpletion of cause of
Th icate i, pag									rmed? 2 ☐ No	Yes	2 □ No
Physician: The law rithis certificate has trail director, page 2 s	Be	25. Was case referred to medica examiner?	Hospital:			2 DOA Othe	26. Place of Deal	th (Check only o	ne)		
This ral du	<u>۲</u>	1 XYes 2 No 27. Manner of Death	1 1,29		ER/Outpatient 28b. Time of	3LI DOA	4 Nursing no	ome 5 Resid			y)
ding I	Fig	1 □ Natural 5 □ Pendir	9 ./-	of Injury oth, Day Year)	Injury	28c. Injury Work		28d. Describe h	F C	101	0 1
Attending or death.	Certification:	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be 385 Place	0/-1	OCT /	et, factory, office	103 27	281 1 000000 (6	er o	Jons Sun	I Route Number,
after Dire	ertil	4 Homicide determ		ling, etc. (Special	(y) STR	727		City or Tow	State	o na	O Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifyir	ig Physician: To th	e best of my kno	owledge, death	occurred at the tim	e, date and place	and due to the	cause(s) and m	anner as a	ated
e Ho: 24 h e Fur etely	edical	(Check only 2 Medical	Examiner: On the	pasis of examination	ation and/or inv	estigation, in my or	pinion, death occur	red at the time,	date and place,	and due to	the cause(s)
omply	Me	29b. Signature and title of certifie		^		29c. License	number		29d. Date signe	ed (Month,	Day, Year)
F 5 F 0) / \/ /	lo 11	()		0	C.M.E.		January	7 20	2004
1	1	30. Name and address of person	who completed cau	se of death (Item	m 23a) (Type F		○ • F1 • Li •		oamat)	20,	2004
5		J ARN	WUF	MO			eet, Bal	timore.	Marvla	nd 211	201
Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Signa						-A 614	201
Regist		JAN 3 0 200	4 Sand	va ,	6 1.	200 1					

			1- For Amend Item 24a per Verb., 6827, 01/30/04(hib) Certificate of Death	and Menta		ene 2 () () L	02392
	Physici		1. Decedent's Name (First, Middle, Last)	2. Date Mor	e of Death	Day Year	3. Time of Death
	/Medic		Thelma V. McCauley	Jan		2004	4:00 A M
	Examin	er	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death		4c. County of Deeth	
			255 Chantry Road Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24 Hrs 0 D.	- (D: 1)	Balti	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2XIF 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hours About 1 Months Days Hours	Min. (Moi	of Birth nth, Day, Y	ear) 9. Birthp	lace (State or Foreign try)
32			Usual Residence of Decedent	Aug	. 20,	1908 V:	irginia
	yland		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Mar-st	tor	MD Baltimore Timonium				1 ☐ Yes 2X No
	or 28,	Director	10e. Street and Number 10f. Zip Code		10g.	. Citizen of Whal Coun	try?
	th will	alD	255 Chantry Road 21093			USA	
	ama ama	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orin If Yes, specify Cuban, Mexican	igin? (Specify Yes	s or No-	14. Race - Americ Bleck, White,	an Indian,
92	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No ☐ ☐ Yes 2 ☒ No ☐ ☐ Yes 2 ☒ No Specify:		,	Specify: Whi	
Ö	ural'	d b	3 20 Wildowed 4 Divorced Year or Dates:				
<u>.</u>	in 72	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most	st of working	161	b. Kind of Business/Ind	dustry
7	with iene.	E O	8 College (1-4or 5+) N/A Dressmaker			Clothing	•
g	othe	BeC	To the state of th	er's Name (First, i	Middle, Mai		3
<u> a</u>	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than *natural; or Itama 23a or 28a-1 show attc event, the Madical Exertine resal be notified at	오	William Bolton Em	nma Mart	tin		
Maryland 21215-0036	Sh F F		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er o <i>r Rur</i> al Route	Number, C.	ity or Town, State, Zip	Code)
	and and n 27			Timonium	n, MD	21093	
ore	Pages 1 and 2 should nent of Health and Men ant: If item 27 is marke ury or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Jan. 19,	200	c. Location - City or To	wn, State
Ē	Pag tmen tant:		`4 □Donation 5 □ Other (Specify)	2004		Timonium	
Baltimore,	permit. Pages 1 and 2 Deportment of Health a Important: If item 27 is any njury or other trae	J	21. Signature of Funeral Service Lice see 22. Name and Address of Facility Lemmon Funeral 10 W. Padonia Ro	Home of	Dular	ney Valley,	Inc.
	2 2		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.				Approximate
Į	Physician		Immediate Cause (Final disease or condition				Interval Between Onset and Death
	/Medical		resulting in death) Due to (or as e consequence of):			7	1-460Y
S	Examiner		Sequentially list conditions. b. Hy Dry (OM) W			1	+ Strv
0.4	g #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				1
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
68760,	ificate be executed g physician and as the burial-transit	aiE					
687	tificate ig phys as the	edicai	d.				
×o	leath certifi attending I I for use as	Ž.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	v
m	death e atte	cla	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)				Day Year
0.	The law requires that the death cert te has been signed by the attendin age 2 should be detached for use i	Physician/M	9 □ Unknown 9 □ Unknown				
	es tha gned se de	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23е	. Did tobac	co use contribute to th	e cause of death?
g	w require been sign				1 🗌 Yes	2 No 3 Proba	ably 4 Nnknown
Records,	lawr as be	Completed		24a	. Was an autopsy	24b. Were autop	sy findings available apletion of cause of
		Con		1 🗆	performed Yes 2	d? death?	
Vital	siclan: Th certificate rector, pag	Be		of Death Check			
0	Physician: this certific ral director,	ို				e 6 Olher (Specify)
	ling After une	o U	27. Manner of Death 1		scribe how i	njury occurred	
<u>s</u>	r Attending er death. rector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury Al home, farm, street, factory, office		tion (Ctros	t and Number or Rural	Pauta Mumbar
Division	of or Attend after death Director: d in by the f	Certification:	4 Homicide determined building, etc. (Specify)		or Town, S.		Houle Number,
	prits urs ara	edical C	29a. Certifier (Check only 2 Medical Exeminer: Or the best of my knowledge, death occurred at the time, date and 2 Medical Exeminer: Or the basis of examination and/or investigation, in my opinion, death	d place, and due	to the cause	e(s) and manner as sta	ited.
	To the Hos within 24 ho To the Fun completely f	Med	one) and manner stated. 29b. Signature and little of certifier 29 License number	an occurred at the		Date signed (Month, E	
)	F S F Ö		D427	36	1	-17-	OL
			30. Name an address of pers vi my completed cause of death (Item 23a) (Type, Print)	M	1	7170	(/
×	Sta	e	31. Date fred (Month, Day, Year) 32 Registrar's Signature	-	01	0,00	7
	Registr		JAN 3 0 2004				-

			For State Registrar		State of M	larylar	nd / Depa <i>Ce</i> a	artmen rtificat	t of H e of l	ealth a Death	and M		giene Reg. No.	Cityren Staff	04	02393
			1. Decedent's Name ((First, Middle, Las	st)					-		2. Date of De	ath			3. Time of Death
	Physic /Medi		Frances	Nortman				Januar					Day	8, 2	Year 2024	09:45PM
1	Examir		4a. Facility Name (If n Saint		street and number, Medical		nter	4b. City, Town, or Location of Death					4c.	County of		imore
	Funeral Director		5. Social Security Nun 406–22–878		ex 7. Aq □ M 25CXF	ge (In yrs. 79	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da October	th y, Year)	1924	9. Birthpla Country Viro	ce (Stete or Foreign y) xinia
	pu ,		Usual Residence of D			1.0										,
	aryla shov	-		10b. County			ity, Town or Lo	cation							100	d. Inside City Limits
	Be-f	Director		Baltimor	æ	ES	sex									1 ☐ Yes ≱ ŒNo
	with t	급	10e. Street and Numb					10f. Zip							hat Country	y?
	eath rs 23	era	929 Woodly	n koad	12. Was Decedent	Euros in 1	10 12 1	212			1.0.10	-7.14	U.S			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than 'naturel', or items 23a or 28e-f show any injury or other traumatic event, it a Madical Examities it and the notified at this.	by Funeral	11. Marital Status 1 □ Never Married 3/XWidowed 4		Armed Forces: 1 Yes 21X If Yes, Give Year or Dates:	?		was Deced f Yes, spec 1 ☐ Yes	ofy Cuba	spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)			- Americar , White, et Whit	c.
9	2 hou	ted		5. Decedent's Ed	lucation		16a. Deced	lent's Usua	I Occupa	ition			16b. Kir	nd of Bus	iness/Indu	
Maryland 21215-0036	d within 7 jiene. r than "n It e Med	Completed	Elementary/Second	only highest gra	de completed) College (1-4or	5+)	Homema	kind of wor 20 NOT us aker	rk done d se retired,	luring mosi)	t of workin	ng		Hom		,
P	othe	Bec	17. Father's Name (Fin	rst, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden .	Sumame)	
<u>a</u>	Ments Ments arked		John Richa	rdson Jo	ordan					Fan	nie N	Mae Bro	oks			
lan	2 sho and is m		19a. Informant's Nam									Route Numbe				
	and ealth m 27		Joyce Baie:	<u>-</u>	nd)		-			bad, I	Balti	imore,	Mary	land	2122	21
Ore	ges 1 t of H if ite		20a. Method of Dispos		Removal from State		Place of Dispo cemetery, cren	natory or of	ther place)		2004			ity or Town	
Ë	tmen tent:		`4 □Donation 5	Other (Specify	<i>'</i>)	Pa	rkwood	_		i		,2004	Bal	timo	re, M	aryland
Baltimore,	Depar impor impor any ir		21 Stonature of Fusion	Licen			1	Name and	olari	ızdzi Laste	nski rn Av	Funera enue,	l Ho Esse	me, x, M	P.A. aryla	nd 21221
				allule. List only	olications that caused one cause on each li	d the deat ne.	th. Do not ente	or the mode	e of dying	, such as	cardiac or	respiratory ar	rest,		In	pproximate iterval Between
	Physician		Immediate Cause (Fir disease or condition resulting in death)	nal	a Conge	stiv	ve Hea	rt F	ail	ure						nset and Death
	/Medical Examiner		rosulting wil doality	- (Due to (or as	a conseq	juence of):									
Q.		-	Sequentially list condition if any, leading to imme	tions,	b. Due to (or as	a conseq	mence of):									
	nted Insit	nln	Cause (Disease or inju	ing	500 10 (01 23	a 00/1309	1001100 01).									
<u> </u>	execu n and iat-tra	Examiner	that initiated events resulting in death) Las	st I	Due to (or as	a conseq	uence of):	-								
68760,	ficate be executed physician and is the buriat-transit	edical		l	d.											
_	tificat ig phy as th				<u> </u>											
P.O. Box	law requires that the death certit as been signed by the attending 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent print the past 12 months of 1 Yes 2 No. 9 Unknown	onths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	Ectopic pre Other (spe					23	3d. Date Montl	of delivery n Da	y Year
	res that signed by be deta		Part II. Other significa	nt conditions co	entributing to death b	ut not res	ulting in the un	derlying ca	iuse giver	n in Part I.		23e. Did to	bacco us	e contrib	ute to the	cause of death?
Division of Vital Records,	w requires been sign	ed by			ive Pulmo							1 🗆 Y	es 2	X 40 3	☐ Probabl	y 4 🗆 Unknown
င္ပ	e lawr has be je 2 sh	Completed										24a. Was a		24b. We	re autopsy	findings available
~	The teh	E C										autop: perfor		dea	or to compl ath? Yes 2[etion of cause of
Ita	ician: Th certificate rector, pag	Be (25. Was case referred examiner?	to medical						26. Place	of Death	(Check only or			1103 20	3.40
<u>></u>	hysic his ca Il dire	္ရ	1 ☐ Yes 2 No		Hospital: 1 Inpatie	nt 2 🗆	ER/Outpatient	3 DO	A Other	4 🗆 Nur	sing Hom	e 5 🗆 Resid	ence 6	Other	(Specify)	
Ē	ing P	0	27. Manner of Death 1 Natural	5 Pending	28a. Date of Inju	y Year)	28b. Time of Injury	1 28	C. Injury : Work?	at	28	d. Describe h	ow injury	occurred		
S	tend death tor: / the f	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be				М		es 2□N						
\leq	or Ar after Direction by	Certification;	4 Homicide	determined	28e. Place of Inju- building, etc	ury - At ho c. <i>(Specif</i>)	ome, farm, stre	et, factory,	office		28	If. Location (S City or Town		Number	or Rural Re	oute Number,
	spital ours neral filled		29a. Certifier	Certifying Phy	sician: To the best	of my kno	wledge death	occurred a	t the time	data and	place or	d due to the o				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	(Check only 2 one)	Medical Exam	iner: On the basis of and manner sta	examina	tion and/or inv	estigation, i	in my opi	nion, death	occurred	at the time, d	ate and p	olace, and	d due to the	o. e cause(s)
	To t To t	Σ	29b. Signature and title	of certifier	11/)	M 1	29c.	License	number		2	9d. Date	signed (Month, Dey	, Year)
•	1.		• /	T - J	· Hel	ou,	1-1-1).	D 1	7695		E	Mu	wa	20	18,2004
	M		30. Name and address	of person who co	ompleted cause of de	eath (Item	23a) (Type, P	rint)								
			Abdallal 31. Date filed (Month, I			D		Osle	n Di	rive	Tow	SONe	Mary	lan	d 21	204
	Sta Registra		OT. Date fried (MONIN, I	1631 0 0	32. Registr	s Signa		Loop	1. 8							
		100		JANJ	LUUT PA	State of the state	D John	The same	Ni.							

			1 - For State Registrar	State of Ma	aryland /		artment of H <i>tificate of l</i>		Mental Hy	giene .No.	2004	02394
	Physic	ian	1. Decedent's Name (First, Middle, La						2. Date of D Month	eath Day	/ Year	3. Time of Death
	/Medi		Gloria Bet		Niznik	Σ			Januar			2:10P M
	Examir	ner	4a. Facility Name (If not institution, give	street and number)		ĺ	4b. City, Town, or	Location of Death		4c.	County of Deat	h
	Funeral Director	ľ	329 Poplar Road 5. Social Security Number 218–26–5976 329 Poplar Road 6. S	ех □ м 2 ∑ F	(In yrs. last b	irthday) Yrs.	Essex If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth lay, Year)	Baltimor 9. Birti 32 Kan	nplace (State or Foreign untry)
-	pu »		Usuel Residence of Decedent 10a. State 10b. County		10a City Tay						- ; ; ; ;	
	laryla ahov	'n	· ·		10c. City, Tov Ess		cation					10d. Inside City Limits
	28a-f	ecte	Maryland Baltimon 10e. Street and Number	.e	ESS		104 7in Code			10- 07		1 ☐ Yes 🏋 No
	s 23a or	ral Dir	329 Poplar Road				10f. Zip Code 21221			Unite	zen of What Co ed State	es
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Department of Heatih and Mental Hygiene. Department of Heatin 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, I're Medical Examinar trausit by motified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba □ Yes 2 💢 No	spanic Origin? (Spin, Mexican, Puerto	ecify Yes or N Rican, etc.)		14. Race - Ame Btack, White Specify: W	
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D	Hygie ther ther		17. Father's Name (First, Middle, Last)		170	Juen	aver	18. Mother's Name	a /Firet Middle			
an	and Mental land Mental land Mental land marked o	o Be								, Maluell	Sumame)	
<u> </u>	shoul nd Me mark	은	John Baublitz 19a. Informant's Name/Relationship (1	Type, Print)	198	o. Mailin	o Address (Street a	Helen C		ner City or	Town State 7	in Code)
X	ulth an 27 is		Janet Wilson-	Daughter				ad, Balti				
ē,	s 1 a of Hea item othe		20a. Method of Disposition		20b. Place o	f Dispos	sition (Name of patory or other place		Date	_	cation - City or 1	
Baltimore,	it. Pages intment of I ortant: If its njury or o		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	')		awn	Cemetery	02/02	/2004	Balt	imore M	aryland
Ba	Depar Impo		* Kathleen W	Teber CF	SP	Day	Name and Addres /id J. We	ber Funer hester St	cal Hom	es, E	P.A.	21231 Taryland
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	icate be executed xx physicien and physicien and sthe burial-transit and	sai Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a C. Due to (or as a	ı consequence	of):						
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.О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal déath		Ectopic pregnancy Other (specify)			2.	3d. Date of delice Month	rery Day Year
ر ا	s that ned t	by P	Part II. Other significant conditions co				derlying cause give	n in Part I.	23e. Did 1	tobacco us	se contribute to	the cause of death?
ğ	w require been sig should b	ed t	valvular hea	rt dis	ease	re	q. av	ti -	10	Yes 2	No 3□Pro	bably 4 Unknown
Division of Vital Records, P.O.	ne law re e has bed age 2 sho	Completed	coagulation							psy prmed?_	prior to co death?	opsy findings available ompletion of cause of
		0	25. Was case referred to medical					26. Place of Death		2 No	1 🗆 Yes	21110
∑ ∶	ysicii is cer direct	0 13	examiner?	Hospital:	nt 2□ER/OL	itpatient	3 DOA Othe	Fig. 4 Nursing Hor			□Other /Speci	4.1
0 1	ig Ph ter th neral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day	/ 28b.	Time of njury	28c. Injury Work	at 2	28d. Describe			(9)
<u>Ö</u>	ath. or: Aff	atlo	1 ☑Naturat 5 ☐ Pending 2 ☐ Accident investigation		rear)	Пјагу		es 2 □No				
DIVIS	at or Affices after de Il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, fa (Specify)	ırm, stre	et, factory, office	2	28f. Location (City or To	Street and wn, State)	Number or Rur	al Route Number,
:	to the hospital or Artending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner state	examination an	e, death d/or inve	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the ed at the time,	cause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)
	within To th	Me	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month,	Day, Year)
) /X 2m	5			D4	4670			1/30/	04
	1		30. Name and address of person who o				Print)				- com mo	
	Q			Sissonmy	601N	J. C	aroline	St Ba	Homor.	mi	2128	7
**	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	,	a a					
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Edward Joseph Nicholson January 28 2004 2:59 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6505 Eastern Parkway Baltimore n/a 8. Date of Birth (Month, Day, Year) Oct. 12, 1 if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 ☐ F 63 1940 Maryland 212-38-0588 Director Usual Residence of Decedent of 2 should be filled within 72 hours after death with the Marylam th and Mental Hygiene. 27 is marked other than "natural", or Itema 23a or 28a-1 show traumatic event, the Medical Examinating must be modified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XX es 2 □ No Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6505 Eastern Parkway 21214 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Local 37 Union Operating Engineer Mechanic 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Nicholson Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Catherine K. Pell / Daughter 3017 White Avenue Baltimore, MD f Health item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If its
eny injury or ot
ance. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 DOther (Specify) Entonbment Moreland Mem. Park Jan. 31,2004 Baltimore, MD 5305 Harford Road 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MONTHS' /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 2 X No To the Hospital or Attending Physicien: Be 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25€No 3□ DOA Certification: To 2 ER/Outpatient this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural 1 Tyes 2 🗆 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Chack only one) 29c. License number 29d. Date signed (Munth, Day, Year) 29b. Signature and title of certifier ddress of person who completed cause of reath (Item 23a) (Type, Print) 21204 1401 OSLER DRIVE N 32. Registrar's Signature 31. Date filed (Month) JAN 3 State Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 🔾

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	Physicia /Medic		SELLATHURAT	NADARAJAH					JAN	20	04	5.25 AN		
	Examin		4a Fecility Neme (If not institution,	give street end number)				4b. City, Town, o	r Location of Dear			_		
			FOREST HAVEN N	URSING HOME		If I los	er 1 Year	CATONS If Under 24 H	VILLE					
J	Funeral Director			5. Sex 7. Age (In 1□ M 2□ F 81	yrs. last birti	(rs. Month		Hours Mi		Day, Year) Country) SRILANKA				
	pue M	ŀ	Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location					11	0d. Inside City Limits		
	f sho	ō	MD BALTIM	ORE	САТО	NSVILLE						1 ☐ Yes 2 🛣 No		
	188 188 188 188 188 188 188 188 188 188	5	10e. Street and Number	ORL	ORIOI		ip Code	·		10g. Citizen of	What Coun	try?		
	ath with	Funeral Director	4507 WILKENS A				228			U.S.A.				
Maryland 21215-0020	be filed within 72 hours efter death with the Marylend stal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exercities must be notified at	Completed by Fune	11. Maritel Status 1 □ Never Married 2 → Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? d 1 Yes 24 No If Yes, Give Yeer or Dates:	rin U,S.			an, Mexican, Pu	(Specify Yes or No arto Rican, etc.)		ck, White, e	etc.		
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Baltimore,	or # of		20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spe	Removal from State	Ob. Place of cemeters ALTW	ATORY	1-25-04 LAUREL, MD							
alt	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Li	censee								NC.		
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1 × 3	Physician /Medical Examiner		23a. Pert1. Enter the Meese, or or shock, or heart failure. List of limmediete Cause (Final disease or condition resulting in death)	nly one ceuse on each line.							*	Approximate Interval Between Onset end Death		
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68760,	the death certificate be executed the attending physician end ached for use as the buriel-trensit	al Examiner		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events	c		onsequence of				EEDING			
×	oentificate anding phys use es the	n/Medicai	resulting in deeth) Last	Due	to (or as e co	onsequence of):				10d. Inside City Limits 1 □ Yes 2 No Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: ASIAN b. Kind of Business/Industry ILANKAN GOVERNMENT iden Surname) TTIU City or Town, State, Zip Code) , MD 21228 c. Location - City or Town, State LAUREL, MD RAL HOME INC. , MD 20707 Approximate Interval Between Onset end Death DINCE Approximate Interval Between Onset end Death DINCE 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 2 □ And Number or Rural Route Number, State State of □ Other (Specify) injury occurred			
Bo.	death ce attend d for us	Cia	Part II. Other eignificant condition	contributing to death but no	nt resulting in	the underlying	i causa di	ven in Pert I	23h Did	tobecco use ce	otribute to	the cause of death?		
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Records,	8 P 9	Completed by		873					24a. Was	an autopsy ormed?	ava	illable prior to npletion of cause		
<u>=</u>	The I	် ပ							10	Y05 212No	10	Yes 2 No		
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of	hys his ld	ا ا ا	1 ☐ Yes 2 ☐ No 27. Menner of Deeth Naturel 5 ☐ Pending	Hospital: 1 Inpatient 28e. Date of Injury (Month, Day Yea	2 ER/Out		28c. Injui	Nursing		dence 6 □Oth how injury occur)		
<u>Ö</u>	Attending in death. actor: After by the fune	atic	2 ☐ Accident investiga	tion		M		Yes 2□No						
Division	of or Attend effer death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - building, etc. (S)		m, street, facto	ory, office		28f. Location (City or To		er or Rural	Route Number,		
*	Hospi 14 hou Funer tely fil	edicai	29a. Certifier (Check only one)	Physician: To the best of my caminer: On the basis of examend manner stated.	knowledge, mination end	death occurre /or investigatio	d et the tir on, in my c	me, date end plac opinion, death occ	ce, end due to the curred at the time,	ceuse(s) and mo date and place,	enner as ste	eted. the cause(s)		
end manner stated. 29b. Signature and title of certifier 29c. License number						se number		29d. Date signe	d (Month, E	Day, Yeer)				
			Ja All Doin	Hallia.	m'		12	8795		1/20/	04			
	h		30. Neme end eddress of person when the same and the same	to completed ceuse of death	(Item 23e) (1	Type, Print)	PA	RK H	ELCOHO	Avi	=1B	ALTOMI		
	Stat Registra		31. Dete filed (Month, Day, Year)	32. Registrer's S	Signature				- 171	. , ,		21208		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Charles E. Pridgeon 1235P M 28 2004 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesaprale Medical Center Tsel Lik HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 21, 1922 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1☑M 2□F Months Days Hours 213-12-2528 81 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harkord Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2221 Erin Way 21015 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
9th Grade College (1-4or 5+) Sheet Metal Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer W. Pridaeon Marie Schwarz ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2221 Erin Way, Bel Air, Maryland Mr. Charles Pridgeon, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 1/31/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Miller 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death/ Immediate Cause (Final disease or condition resulting in death) Chronic Obstruction Lung Disease Enysitian 18 mouth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Ischemic (teart Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Pridgeon, Charles this certificate has rel director, page 2 autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EV/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral completely filled Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one)

State Registrar 29b. Signature and title of certifier

ideal Stund

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 432. Redistrar's Signature

Vincenta Giminaro, Do 60205, Atino

29c. License number

MD

40054139

2) Suit-208 Bel Air, MD 2001

29d. Date signed (Month, Day, Year)

January 28, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Yeer Ida Pace /Medical Januarv 2004 10:12 a 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7101 Bay Front Drive, #104 Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 10, 19 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 □ M 2**X** F 90 Director 208-03-0211 1913 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location rai', or itams 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD Director Anne Arundel 1 ☐ Yes 2XXNo Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 7101 Bay Front Drive, #104 21403 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes **②**No
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: 3 XWidowed 4 ☐ Divorced White "natural". the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permil. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If Item 27 Is marked other th,
any injury or other traumation 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Simpson 2 Jane Caroline Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lynch (Daughter) 1976 Scotts Crossing Way, #101, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem 1/30/2004 Adelphi, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ひんのへのへつ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery ŏ 3 Ectopic pregnancy Year 4☐ Pregnant at time of death Day P.O. E 5 Other (specify) been signed by the a should be detached f 1 ☐ Yes 2 ② No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ. Records, Completed 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 □ 1√0 1 🗌 Yes ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury within 24 hours after death. To the Funeral Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the f 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai 29b. Signature ar 29d. Date signed (Month, Day, Year)

Registrar

Y

State

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31. Date filed (Month, Day, Year)

JAN 3 0 2004

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CT.

32

32. Registrar's Signature

105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Malto

			1 - For State Registrar	State of Maryla		artment of H			iene 19. No. 200	4 02399
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	Physicia /Medic	_	Ruth Anna	Pucket	t			January	$25^{\text{Day}}, 2004^{\text{ee}}$	11:00 a ^M
	Examin	_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Deat	h	4c. County of De	eath
			Lorian Nursing Ho	ome		Co1um	bia		Howard	
*	Funeral		Social Security Number 6. Sex	M 2875	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9.8	Sirthplece (State or Foreign Country)
	Director		213-09-8223	92	Yrs.			Sept. 14		Maryland
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	sho	ក			•					1 ☐ Yes 2√ No
	the N	Director	Maryland Baltimor 10e. Street and Number	e C	Catonsv	10f. Zip Code		10	Og. Citizen of What	
	a or	급	707 Maiden Choice	Iano Ant	9107	21228				oodinay.
	eath	by Funeral		2. Was Decedent Ever in		Was Decedent of H	ispanic Origin? (S	pacify Yas or No-	USA 14. Race - Ar	mericen Indian,
	ter d fterr	S	1 ZNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖫 No	0.0.	If Yes, specify Cuba	in, Mexican, Puerl	o Rican, etc.)	Black, Wi	
38	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: V	√hite
ğ	2 should be filed within 72 hours after death with the Maryland and Menfler Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumstic event, the Medical Examinat must be notified at	ted	15. Decedent's Educ		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	ss/Industry
7	n n n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wor f)	rking		
2	d with giene or the	mo	12	College (1-401 54)	Pay	roll Depa	rtment		Departmen	nt Store
פ	othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M		
<u>a</u>	Ald be denta rked rked	To B	Wellington	B. Puck	ett	100	Anne		Mosmil	ller
ary	should had a man		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, State	, Zip Code) 21228
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Heatils and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		Thomas B. Puckett	(Brother)	707 1	daiden Chesition (Name of	oice Lan	e. Ant. 9	107. Cate	nsville,MD
Je.	item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place	e) (Date	20c. Location - City	or Town, State
Ë	Page not: If ny or	j	1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ba	Loudor	Tatory or other place Cremato: Park	ry @ 1/:	30/04	Baltimore	, Maryland
alti	partition partit	İ	21. Signature of Funeral Service Liouns	E	22	2. Name and Addres	ss of Facility	and the second s	rk Funera	
Ö	Department Department		1		1	3620 Wi	lkens Av	e., Balti	more, MD	21229
-	05-20		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea	ath. Do not en	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final	o cause on each line.	ml	an1	Can	CEY		Onset and Death
	/Medical		disease or condition resulting in death)	. Due to (or as a conse	equence of):	-010	COMM			17 WEEKS
п	Examiner									
		Je.	Sequentially list conditions, If any, reading to immediate cause. Enter Underlying	Due to (or as a conse	quarica of).					
	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events							
ó	an ar rial-t	EX	resulting in death) Last	Due to (or as a conse	equence of):					
8760,	ysicii	dical								
9	death certificate be executed e attending physician and nd for use as the burial-transit	led								
Вох	leath certific attending p	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregr 1□Live birth 2□Fei		Ectopic pregnancy			23d. Date of c	,
		sicia	in the past 12 months? 1 ☐ Yes 2,☑ No	4 Pregnant at time of		Other (specify)			Month	Day Year
P.O.	that the de ad by the detached	hys	9 Unknown	9 Onknown						
	law requires that the as been signed by th 2 should be detache	by F	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause givi	en in Part I.	23e. Did tob		to the cause of death?
ğ	w require been sig should b	ed						1 □ Ye	s 2 No 3	Probably 4 SUnknown
သ္တ	law requ	Completed						24a. Was ar		autopsy findings available
æ	The te h age	Eo						autopsy perform	ned? death'	o completion of cause of ? es 2 No
ta	ician: Th certificate rector, pag	4	25. Was case referred to medical				26. Place of Dea	th (Check only one	-	20110
Division of Vital Records,	S S S	To B	examiner? 1 ☐ Yes 2 🛣 No	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing H	lome 5 ☐ Reside	nce 6 □Other (St	pecify)
0	g Ph er th eral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c, Injun Worl		28d. Describe ho		
<u>Ö</u>	Attending in death. ector: After by the funer	atlo	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(month, buy rour)	quiy		Yes 2 □ No			
Vis Vis	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Str City or Town		Rural Route Number,
Ö	s atte	Certification:		building, stc. (Spec				July Of TOWN	, 0.010)	
×	e Hospital 124 hours a E Funeral I letely filled		29a. Certifier 17 Certifying Phys	ician: To the best of my kr	nowledge, deat	h occurred at the tim	ne, date and place	, and due to the ca	use(s) and manner	as stated.
	To the Hospital or Attending Phwithin 24 hours atter death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Examir one)	ner: On the basis of examinand manner stated.	ration and/or in	vestigation, in my of	pirtion, death occu	rred at the time, da	ite and place, and d	ue to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	(t_ (Δ	29c. License	a number	29	d. Date signed (Mo	nth, Day, Year)
1			Hueda H	ti Chan	IM. T). D	4332	13 -	Jan-2	7 2004
	0		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type,	Print) 100	220	Hickory	al Di	100 0- 1
	1				No.	. [/ 50	1 1 1	11 11	Y CI IN III	THE KINA
60	1		COLUMBIA,	MO 210	744	· ABE	OA A	LI KH	ATV	age Road

State of Maryland / Department of Health and Mental Hygiene 02600 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** January 18, 2004 9:45 AMM Olive Quinn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Glenmeadows Retirement Center Glen Arm If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 8. Date of Birth (Month, Day, Year) Aug 1, 191 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 432-26-6944 89 Yrs Arkansas Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Exal-shermest be notified at MD Baltimore Glen Arm 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 11630 Glen Arm Road 21057 USA filad within 72 hours after death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 X Divorced "netural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) teacher education .. Pagas 1 and 2 should be filad v tment of Health and Mental Hygie tant: If item 27 Is markad other t ijury or other treumetic evant, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Lynn Westbrooke Clara Clifton Jones 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenmeadows Retirement Ctr 11630 Glen Arm Road, Glen Arm, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o important: If eny injury or once. 4 X Donation 5 ☐ Other (Specify) Ronal S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 man Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE **Physician** weeks /Medical Examiner ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Examiner or Attending Physicien: The law requires that the death cartificate be executed HERO nis certificate has baen signad by the attending physician and director, page 2 should ba detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🔀 Vo Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMBNOTA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3□ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funarel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number (Inom 23a) (Type, Print) ROLLING CROSS ROADS 32/Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 0 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** herine m. Reese /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner 9200Franklik Genesis Franklin woods HO, ME 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2√2 F Director Aug20,1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location f Health end Mental Hygiene. Ittem 27 is marked other than "nature!", or frems 23s or 28s-fehov other traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits MD Baltimore Director Essex 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 917 Woodly Road 21221 USA death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours effer of Depertment of Health end Mental Hygiene. Important: If them 27 is marked other than "many injury or other its any injury or other its and injury or other its a Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 2 SpecifyWhite 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ John R. Lewis Catherine Stuehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Reese /son 915 Martin Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HollyHillCemetery 1/30/04 Baltimore MD 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical cell lymphoma in the lung 2 months Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the deeth certificate be executed attending physician end for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? COPI 2 2 No 2D No 1 🗆 Yes within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Medical Certification: To I 1 ☐ Yes No Other: 2 ☐ FR/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0051 10 30, Name and address of present who completed cause of death (Item 23e) (Type, Print) eronica 31. Date filed (Month, Day, Year) 32. Régistrer's Signature State JAN 3 0 2004 Jane J Registrar

DHMH 16 Rev 6/95

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State of Mar	yland / Departmer	nt of Health and	Mental Hyg	iene 🦳 🤇

		1 - For State Registrar 1. Decedent's Name (First, Middle,)	(ast)	061	tificate of	Death	2. Date of Dea	Reg. No.		3. Time of Death
Physici /Modic		LESLIE			RUFFI	N .	JANUARY	17, 20	0 4 ^{ar}	11:09 AM
/Medic Examin		4a. Facility Name (If not institution, 9			4b. City, Town, o	or Location of Death Heights		4c. County Prince		orge's
Funeral Director		228-20-1025	. Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 6	, Year) , 1924	9. Birthp Cour Virg	place (State or Foreign ntry) ginia
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	10d. Inside City Limits
Mary B-f ah	tor	MD Prince	George's Ca	pito1	Heights					1¶Yes 2☐No
or 28	Director	10e. Street and Number	11 D 1		10f. Zip Code			10g. Citizen of V		ntry?
eath v	eral	6803 Walker Mil	LI Road 12. Was Decedent Ever in U.	S 13 1	20743		acify Vas or No-	14 Bace	USA a · Americ	can Indian,
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28e-f ahow other traumatic event, the Medical Evament must be notified at	by Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced	Anged Forces? 1 Yes 2 No05/0 If Yes, Give) 8/45	f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify	k, White,	etc.
2 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation during most of work d)	cina .	16b. Kind of Bu	siness/Inc	dustry
12 should be filed within 7 n and Mental Hygiene. 7 is marked other than "n reumatic event, the Med	Completed	(Specify only highest Elementary/Secondary (0-12) 0	College (1-4or 5+)		cel Worke		ang	Priva	ate	
be file tal Hy d othe	Be	17. Father's Name (First, Middle, La	sst)			18. Mother's Nam			е)	
d Meni	은	Ned Ruffin 19a. Informant's Name/Relationship	(Time Driet)	40h Maille	- Add (Ct	-	u Flowe		Chana Zi-	Codel
id 2 st th and 27 is r traur		Lionel Finley -			_	Road, Sil		-		
es 1 and of Health f item 27 r other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other pla	T -	Date	20c. Location -		
Pag nent ent: I		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe	☐ Hemoval from State	ltenha	m Vet. C	Cem. 1/28/	04	Che1ter	nham,	MD
permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr		21. Sign true of Funeral Service Lie	epsee			ess of Facility La La Ave., N				
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the death	n. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. CORONARY ART		SEASE		· <u> </u>			
	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (brise a consequ	ienoa of):						
ificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (or as a consequent	uence of):						
= 0 0	an/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnanc	v		1	e of delive	
t the d by the ached	Physiclan/M	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)	· 		Mor	nth 	Day Year
res tha igned l		Part II. Other significant condition	s contributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.				ne cause of death?
w requir been si should	ted	CHRONIC OBSTRUC	CTIVE PULMONARY	DISEAS	E,		1 □ Y	es 2 No	3 Prob	ably 4 Unknown
	Completed by	ATRIAL FLUTTER,	HYPERTENSION				24a. Was a autop perfor 1 Yes	sy p mad? d	Vere auto prior to con leath? Yes	psy findings available mpletion of cause of 2 No
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Deal				
Phys this ral dii	7: To	1 ☐ Yes 2 🔼 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of	28c. Injui	ry at	ome 5 🔀 Resid 28d. Describe h			y)
fe A Figure	atlor	1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investiga		Injury	M 1	rk? Yes 2 □ No				
el or Attendes after death	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			eet, factory, office		28f. Location (S City or Tow		er or Rura	l Route Number,
To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physicien: To the best of my kno- caminer: On the basis of examinat and manner stated.	wledge, death tion and/or in	occurred at the till vestigation, in my o	me, date and place, opinion, death occur	and due to the or red at the time, o	ause(s) and mai late and place, a	nner as st and due to	ated. the cause(s)
To the within 2 To the I complet	Me	29b. Signature and title of certifier	Jagar My	\\	29c. Licens	D0055061		29d. Date signed		
		30. Name and address of person was	o completed cause of death (Item	23a) (Type,	Print)					
		AUBRIE'J. NAGY,								

State Registrar DHMH 17 Rev 1/2001

JAN 3 0 2004

32. Registrar's Signature

AN			For Unpended Item#2:	State of Ma Ba,27,Per ME	ryland / Depa , G828,2/17/0	artment of H	ealth and N Death	Mental Hygi	ene 004	02403
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
и	Physici		Tyrone Kearn Robi					January	19, 2004	1238 P ^M
	/Medic Examin		4e. Facility Name (If not institution, give :	street and number)		4b. City, Town, or	Location of Death		4c. County of De	
	Zxami		Southern Maryland	Hospital	Center	Clinto	n		Prince	George's_
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 18,	Year) 9. Bi	rthpiece (State or Foreign
	Director		578-96-2151	M 2□F	42 Yrs.	liloning Days	TIOUIS INITI	Dec.18,	1961 Wa	shington, DC
)	pu &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation			,	10d. In side City Limits
	sho	7			Suitland					1 No 2 No
	the N	Director	MD Prince Ge	20166 3	Dureran	10f. Zip Code	<u> </u>	10	g. Citizen of What C	Country?
	with with	ā	2400 Shadyside Av	70 1 110		2074	6		-	SA
	172 hours after death with the Maryland "natural", or items 23e or 28e-f show rdical Examiner must be natilised at	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hi		pecify Yes or No-	14. Race - Am	nerican Indian,
(0	riter	필	1 ANever Married 2 Married	Armed Forces?		f Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black, Wh	
93	al', o	þ	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🖾 No	Specify:		Specify: B	lack
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	ient's Usual Occupa	ation Jurina most of wor	kina 1	6b. Kind of Busines	s/industry
2	within lene. than "I	npi	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired, struction)		Private	
2	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)		Con	oci uccion		ne (First, Middle, M.		
anc	ould be fi Mental H warked of	Be	Joseph Robinson,	Sr.					s Robinso	n
Maryland	s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Madical	ဥ	19a. Informant's Name/Relationship (Ty		19h Mailir	n Address (Street a	and Number or Ru	ral Route Number	City or Town, State,	Zin Code)
Ma	d 2 sho th and t7 ie m		Bobbie J. Robinson						MD 20746	
ā,	Health tem 27 tother tra		20a. Method of Disposition	010001	20b. Place of Dispo	sition (Name of			Dc. Location - City o	
no	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☑ Donation 5 ☐ Other (Specify)	temoval from State	-	natory or other place et Cemete		/04 W	ashington	n, D.C.
Baltimore,	permit. Pages 1 a Department of Hes Importent: If item any injury or othe once.	Ιi	21. Signatura Funeçal Service Licens	88 1				atnev's F	uneral Ho	ome
Ba	permit. Departr Importe any inju	3	1 Calph Vo	I luce					ngton, DO	
			23a. Part1. Enter the disease, or compl	ications that caused to	the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician	. 1	shock, or heaft failure. List only of Immediate Cause (Final	Chronic A						Onset and Death
	/Medical		disease or condition resulting in death)	3.	consequence of):					
п	Examiner		O CONTROL BARRANTA	0.						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):					
	cuted	Examine	that initiated events	o						
0,	be executed sician and burial-transit	Ä	resulting in death) Last	Due to (or as a	consequence of):					
8760,	the	dical		d						
9 X	ath certific attending p for use as	Mec	IF FEMALE:	IZa If was sutsame a	4 acamana)					1
Вох	ath cer attendin for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	eliv <i>er</i> y Day Year
o.	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at t 9□ Unknown	ime or death 5 [Other (specify)				
ď.	The law requires that the tee has been signed by thoage 2 should be detache		Part II. Other significant conditions con	ntributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ds,	uires tha signed id be dei	d by						1 ☐ Yes	2 □ No 3 □ F	robably 4 Unknown
50	w require been signature	ete						24a. Was an	24h Were a	uitonsy findings available
Vital Record	The lav	Completed						autopsy	ad? ∣ dea,¥h?	
		ပိ	25. Was case referred to medical				OC Plans of Das		□ No 1 A Ye	s 2 No
⋚		To Be	examiner?	Hospital:	t 2 X ER/Outpatier	t 3 DOA Othe	26.	th (Check only one	ce 6 Other (Sp.	acity)
of	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe hov		эспу)
ion	nding ath. r: Afte	atio	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Yeer) Injury		res 2 □ No			
Division	or Atten after deat Director: in by the	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur	ry - At home, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F	Rural Route Number,
ā	tal or	Certification:	T LI TIOMICIA	building, etc.	(0)00.197			o., o. , o,	0.0.0	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer				f my knowledge, deat examination and/or in					
	To the within 24 To the F complete	Medical	one)	and manner stat						
_	To To Cor		29b. Signature and title of certifier	mid		29c. License			d. Date signed (Mor	
			my hu.	· '		0.C.	M.E.	J	anuary 20), 2004
			30. Name and address of person who co	ompleted cause of de			eet Ral	timore M	aryland 2	21201
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	de Oien et		cc, bul	CHICAGO P	mary action 2	. 1601
	Registi		JAN 3 0 2004	Benero	19 As	rocks				

			1 - For Amend Items 8	State of	of Ma 827,	ırylan 01/30,	d / Depa /04d i @e <i>r</i>	irtment of	Hea f De	alth a e <i>ath</i>	ind Men		ene 2	004	02	
			1. Decedent's Name (First, Middle, Las									Date of Death		Vaar	3. Time	of Death
	Physici /Medic		Virginia Romanows	ci							C	Monih)1	22	2004	5:40) <u>A</u> M
	Examin		4a. Facility Name (If not institution, give 222 S. Ann Street	street and nu	mber)			4b. City, Town Baltim		cation of	f Death		4c. Cour	nty of Death		
	Funeral Director		5. Social Security Number 6. Se 220–24–1758	x □ M 2 M F	_	(In yrs. i 73	last <i>birthday)</i> Yrs.	If Under 1 Ye Months Day		Under 2 Hours	24 Hrs. 8. (Min. 01	Date of Birth]	/20/31 04 -	9. Birth	ntrv)	or Foreign
	P .		Usual Residence of Decedent			40- 0'-	-									
	arylar	<u>.</u>	10a. State 10b. County				y, Town or Lo	cation							10d. Inside	City Limils es 2 □ No
	28a-1	Directo	Maryland N/A			Balt	timore	101 7: 0:1				140	. 00:	of What Cou		
	with		222 S. Ann Street					10f. Zip Code 21231	9						•	
	Jeath Ins 23	Funeral	11. Marital Status	12. Was Dec	edent E	ever in U.	S. 13. V	Vas Decedent of	f Hispa	anic Orig	in? (Specify			State:		
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8	hour	ed b	15. Decedent's Ed	Year or E	Zales.		16a, Deced	ent's Usual Oc	cupation	n		1	6h Kind of	Business/In		
715	nin 72 in °na Medic	Completed	(Specify only highest gra-		1-4or 5	4)	(Give life. L	kind of work do OO NOT use ret	ne durin ired)	ng most	of working	·	35. (11173 61		,	
212	d with	Com	Elementary/Secondary (0-12)	College (1-401 3	*)	Homema	aker				D	omest	ic		
D	al Hygi al other	Be C	17. Father's Name (First, Middle, Last)						18.	. Mother	r's Name (Fil	rst, Middle, M	aiden Sum	ame)		
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve <u>pnce</u> .	70	Unknown Thomas								Ann Un					
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altimore,	Pages nent of h int: If its ury or of		1 ☐ Burial 2 MiCremation 3 ☐		State	C	emetery, cren	natory or other p		0				•		
	iit. Partmer artmer ortant injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service U 2n	,		payv	1,111	rematory Nameant Add				004 Ba			aryıa	na
Ba	permit. Departi Import any inj once.		Dr. 1	1/2/		-		Name and Add						-	bac l	21221
	-77		23a. Part1. Enter the disease, or comp	lications that	caused	the death								Mary.	Approxim Interval B	
ı,	- Pnysician		shock, or heart failure. List only of Immediate Cause (Final	one cause on	each lin	θ.	0							- 2	Onset an	d Death
	/Medical		disease or condition resulting in death)	a. Due lo	(or as	consequ	uence of):	cer						- 12	3mor	1745
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m	death a atter	iclar	in the past 12 months?	1□Live I 4□Preg	nant at			Ectopic pregnal Other (specify)						Aonth	Day	Year
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S,	as the	by P	Part II. Other significant conditions co	ontributing to d	leath bu	ıt not resu	ulting in the ur	iderlying cause	given in	n Part I.		23e. Did toba	cco use co	intribute to t	ne cause o	f death?
ord	w require been si should b										_ /	1 🔁 🕻 es	2 🗆 No	3 Prob	ably 4	□Unknown
Vital Record	e lawr has be je 2 sh	Completed										24a. Was an autopsy		. Were auto	psy finding	s available cause of
		Соп										performe	od? No	death? 1 ☐ Yes		
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	(Japania)						B. Place	of Death (Ch	neck only one			-	
5	Physi this o	T-	1 ☐ Yes 2 Mo 27. Manner of Death	Hospital: 1 D 28a. Dale	Inpatie		ER/Outpatien	3L DUA		4 🗌 Nur		5 Residen			y)	
Division of	ding h. After funer	Certification:	1 Matural 5 Pending 2 Accident investigation	(Mor	oth, Day	Year)	28b. Time of Injury	28c. In V M 1		2 🗆 N		Describe how	r injury occ	urrea		
VIS	or Attendi after death. Director: A in by the fu	ifle	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place	of Inju	ry - At ho	me, farm, stre	et, factory, offic	8			Location (Stre		nber or Rura	l Route Nu	ımber,
	pitel or A ours after neral Directilled in by	Cert	Tollions	Build	arg, oc	. (Specify						ony or rown,	J. 218/			
	To the Hospitel within 24 hours a To the Funeral C completely filled i	edical	29a. Certifier 1 Check only 1 Medicel Exem	sician: To the biner: On the band man	asis of	examinat	wledge, death tion and/or inv	occurred at the estigation, in m	time, d y opinio	date and on, death	d place, and o h occurred at	due to the cau t the time, dat	se(s) and i e and place	manner as s e, and due to	tated. the cause	(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1				29c. Lice	nse nu	ımber	, p	290	d. Date sign	ned (Month,	Day, Year)	. , ,
			David Si	wi		DO		#4	3:	23	4	Jo	an va	ry	22,2	2004
	3		30. Name and address of person who o	completed cau	se of de	ath (Item	23a) (Type, I	Print)	'n	,	0	14.	4	Ma	1 21	27//
	Sta	te	31. Date filed (Month, Day, Year)	¥U √32. F	<u>)</u> Registra	y's Signal	tyle	rern	1	V /	1291	1 m	ore	1110	2/	227
	Registr		JAN 3 0 2004	perpa	مرايستر	1	M	souks!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖺 🗎 📗 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 640 M Robert O. Reynard, Sr. JAN ZCC 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth BAUTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1X M 2□ F 173-24-2146 70 18, 1933 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Halethorpe 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1817 Selma Ave. 21227 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? VXYes 2 □ No 1959-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1961 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Professor College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oliver Reynard Genevieve Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 Selma Ave. Joan A. Reynard, wife Halethorpe, MD. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 02-02-2004 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeçal Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. Johns 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Ce: Due to (or as a consequence of) FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of ENAL ue to (or as a consequence of): 14 days IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe NODE 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Box 68760 o Records, Vital ZEYNAC) Division of the Hospitel or Attending

)

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

the Medical Examiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other trairmant.

Physician

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Examiner

and

the attending physician

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Baltimore, Maryland 21215-0036

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State Registrar

31. Date filed (Month, Day, Year)

ARUW GAMN

29b. Signature and title of certifier

3 0 2004

MI) 32 Registrar's Signature

MAKCUSGANNMD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON

29c. License number

29d. Date signed (Month, Day, Year)

ORIGINAL

		1 - For Amend Item 23a per State Registrar	State of Marylar	nd / Depa /04dhb	artmer rtifica	nt of H	ealth a	and M			2001	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Francis S.	Reber						2. Date of De Month JANUAR	Day	Year 200	
Examin		4a. Fecility Name (If not institution, give s Saint Joseph		nter	4b. City	Town, or	Location o	Death OWS	on	4c. (County of Dea	ath ltimore
Funeral Director		100 14 3020	M 2□F 7. Age (In yrs.		If Unde Months	n 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir Month, Da May I	th Year) 9	9. Bi	rthplace (State or Foreig Cunry) Cunsylvania
be filed within 72 hours after death with the Maryland ital Hygiene. do ther than "natural; or items 23a or 28a-f show event, the Modical Exercitival relative reciliad at	tor	Usual Residence of Decedent 10a. State 10b. County Md. Baltimor		ty. Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 No
h with the	al Direc	10e. Street and Number 624 Yarmouth Roa	ıd		10f. Zi	Code 212	86			10g. Citiz	en of What C	ountry? USA
urs after deat	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	i	4. Race - Am Black, Wh Specify Whi	
within 72 hours jiene. r than "natural", ine Medical Ext	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Dece (Give life. Teac	kind of wo DO NOT i	al Occupa ork done d ise retired	ation Juring most)	of workii	ng		d of Business	·
	To Be Co	17. Father's Name (First, Middle, Last) Harvey Reber					Flo	renc		, Maiden S	Sumame)	
alth a		19a. Informant's Name/Relationship (Type Mrs. Betty Reber/	Wife	62	4 Yar	mout	h Rd.		Son, Mo			Zip Code)
nent of Hes int: If itam iny or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, crer rch Hi	natory or o	me of other place emete	ry 1		04		ville,	
Department of I		21. Signature of Funeral Service License	8	22	Rusk Rusk	nd Addres Tow Yor	s of Facility SOD F K Rd.	uner Tow	al Home	a: In	204	
nysicia nysicia ne bur	Ical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	ATION quence of):			Pneumo GEST		LUNGS	ì		Interval Between Onset and Death
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gne be c	by	Part II. Other significant conditions com-			, ,	ause give	n in Part I.					o the cause of death?
ate has page 2	Completed				··-				24a. Was autop perfo	rmed?	prior to death?	utopsy findings available completion of cause of s 2 No
is co	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ospital: 1 💢 Inpatient 2 🗆	ER/Outpatien	nt 3 DO	Othe			Check onl o		□Other (Spe	ecity)
iner i	ertification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury Work	at	2	8d. Describe h			
E gird	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	(y)					City or Tow	vn, State)		ural Route Number,
24 hours Fune letely fil	Medical	29a. Certifier 1 X Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a h occurre	nd due to the o	cause(s) a date and p	nd manner a place, and du	s stated. e to the cause(s)
withir To th comp	Me	29b. Signature and title of certifier			29	C. License	number 8244				signed (Mon	th, Day, Year)
And the state of t		30. Name and address of person who con				15-	TALIC	MAI	MARYL	OMB	21200	5.
Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	3/1\1\	V Inn B	1 m 44 m	57 8 M at	CIPTINE L	.mru.	have if him Wal de	T

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#23A

State of Maryland / Department of Health and Mental Hygiene 1

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W	Com	tich		3

			1 - State Registrar		,	Cer	rtificate	of L	Death		,	Reg. No.	ione facili	V	0 5 3 5 1
	Dhamin		1. Decedent's Name (First, Middle, La	•							2. Date of De	ath		Уель	3. Time of Death
	Physici /Medi		Arthur Richard								Janua:				11:10 PMM
	Examir	ner	4a. Facility Name (If not institution, given Augsburg Luth	eran Ho	me		4b. City, T Balt	imo	re				County	of Death	
	Funeral Director		717-07-7576	Sex I∭M 2□F	7. Age (In yrs. last I	Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Aug 13	th ly, Year)	15	Cou	place (State or Foreign htry) Land
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation								10d. Inside City Limits
	ath with the Marylan 23a or 28a-f show ust be notified at	ţ	Md			Balt	imore								1XŽ Yes 2 ☐ No
	th the	Director	10e. Street and Number				10f. Zip (Code				10g. Citiz	en of V	Vhat Cou	nt ry ?
	23a (23a usat b		6811 Campfield	Road					207				US		
	er de.	Funeral	11. Marital Status	Armed Fo		13. \	Was Decede f Yes, speci	nt of His fy Cubar	spanic Ori n, Mexican	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.))- 1		e - Americ k, White,	can Indian, etc.
	hours after death with the Maryland tural', or Items 23a or 28a-1 show al Exart fract rust be rivilial at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 X Yes If Yes, Gi Year or D	ve _		1 ☐ Yes 2	No.	Specify:				Specify	: b1	ack
	be filed within 72 hours after dea stal Hygiene. ed other than "natural", or Items avent, the Medical Exam ret m	Completed by	15. Decedent's E (Specify only highest gr	ducation	16	a. Deced	dent's Usual kind of work	Occupa	tion	t of working		16b. Kin	nd of Bu	ısiness/In	dustry
	within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (life. L	DO NOT use	retired)	uring mos	t of workin	ig		+		
	e filed withi		12			-	wai		40 14-45-	d. M	(F) 15 d.d.			aura	
		To Be	17. Father's Name (First, Middle, Last Arthur Leonar		rdson						(First, Middle, Anders		Sumam	··············	
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship		19						l Route Numbe	-		State, Zip	Code)
	is 1 and 2 of Health a item 27 is other tree		Leonrd Welling/	nepnew	20b. Place		Falr sition (Name		∛ Roa		ltimore	_		1207 City or To	own, State
	Page nent o ant: If arry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 🖔 Donation 5 ☐ Other (Speci	(y)	State ceme	tery, cren	natory or oth	er place	1						
	permit. Departri Importe any inju		21. Signature of Euneral Conditions of Ronal I de Sice	Wade, I	rigector		ate A				655 W.	Ba1	timo	ore S	Street
			23a. Parkt. Enter the disease, or conshock, or heart failure. List only	plications that one cause on a	caused the death. Deach line.							rrest,			Approximate Interval Between
1	nysician	D g	Immediate Cause (Final disease or condition	а	Cov	(See	hice	Nec	vt	Fail	J-2				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequence				:		,				
	LXammer	<u></u>	Sequentially list conditions,	b. Oire to	工3 (or as a consequence	chen	v z	Cau	18/10	ayon	Jenty	41.5			javs.
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500.0	(or do d octooquerio	017.									/
	ertificate be executed ling physician and e as the burial-transit	Examine	that initiated events resulting in death) Last	cDue to	(or as a consequenc	e of):									
•	ate by	Medical	•	_ d											
	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the bural-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live t	tcome of pregnancy birth 2 Fetal dea nant at time of death lown		Ectopic pre Other (s <i>pe</i>					2:	3d. Dat Mor	e of delive	ery Day Year
	that the	Ph	Part II. Other significant conditions	contributing to d	eath but not resulting	; in the ur	nderlying ca	use give	n in Part I.		23e. Did t	obacco us	se contr	ibute to the	ne cause of death?
	uires n sign										1 🗆 🕆	Yes 2€	3-No	3 🗌 Prob	pably 4 Unknown
	≥ <u>¬</u> ∨	Completed			. "		-	_			24a. Was		24b. V	Vere auto	psy findings available
	The lay ate has bage 2	E				-					autor perfo	osy rmed? 22 No	d	rior to co leath? Yes	mpletion of cause of
		BeC	25. Was case referred to medical						26. Place	of Death	(Check only o				
	S D	10 10	examiner? 1 ☐ Yes 2 ÆNo	Hospital: 1 🗆		Outpatien	it 3□ DOA	_	4 EDNU	rsing Horr	ne 5 🗆 Resid	dence 6	□Othe	er (Specif	y)
		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon	of Injury 28b th, Day Year)	. Time of Injury		c. Injury Work			8d. Describe I	how injury	occurr	ed	
	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not to		- 4 leine - 44 heer	fa	M		es 2 🗀 l		Of Lagation (Care a a a a a	l Missonia		J. Charata Alizantia
	tel or Atras after of al Directed in by	Certification:	4 Homicide determined	200. Place	e of Injury - At home, ing, etc. (Specify)	tarm, str	eet, factory,	office		2	City or Tox	vn, State)	Numbi	ar or Hura	d Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		miner: On the b	e best of my knowled pasis of examination iner stated.										
	To the I	Ž	29b. Signature and title of certifier)	29c.	License	number	~					Day, Year)
			00 11	and a last of the	no of doubt // 55	N (7:	Dain!	V	3/3	15		701	nua	7	,7004
			30. Name and address of person who	completed cau	se of death (Item 23a	i) (Type, Mci		4	0	يالمسر سالم	^^	D 3	רון י	,	
Į	Sta	ate	31. Date filed (Month, Day, Year)	39. F				-	ハマロ	1000		· ()	-110	6	
	Regist		JAN 3 0 200	4 Beat	Registrar's Signature	die	all i								
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			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment <i>tificate</i>					giene	104	02408
			1. Decedent's Name (First, Middle, Last,							2. Date of Dea	th		3. Time of Death
	Physici /Medio		Ersel J. Shewbr	idge						Month JANUAR	Y 7,	Year 2004	18:45 M
9.	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location	of Death		4c. Cou	nty of Deeth	
LS.			MEMORIAL HOSPITAL				BERL				ALLI	EGANY	
	Funeral		5. Social Security Number 6. Set	7. Ag M 2 ☐ F	e (In yrs. last birthday)	If Under 1 Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
	Director		217-10-1043		84 Yrs.	L				Jan 20,	1919	Mar	yland
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation						1	Od. Inside City Limits
	Mary Hah Fed	ţ	MD Allegany		Cumber	rland				-			1 ☐ Yes 2 ☐ No
	r 28a	rec	10e. Street and Number			10f. Zip (Code			1	l0g. Citizen	of What Cour	ntry?
	h witi	Funeral Director	11106 Sunrise Ave	nue SE			21.	502			Ţ	JSA	
	deat	ner	11. Marital Status	12. Was Decedent Apped Forces?	Ever in U.S. 13. \	Vas Decede	ent of His	spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ	
တ္တ	or Ite	F	1 Never Married 2 Married	1 Yes 2 1	No	Yes 2		Specify:		nican, etc.)		Black, White,	
8	ural',	d by	3 Midowed 4 Divorced	Year or Dates:				Specify.			Spe	cny: W	hite
ζ.	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-1 show Ite Madical Examiner must be millind at	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)	16a. Deced	lent's Usual kind of work DO NOT use	c done di	urina mos	t of worki	ing	16b. Kind of	Business/In	dustry
12	withi ene. than	E C	Elementary/Secondary (0-12)	College (1-4or 5	i+)	chauf	,						
0	filed within Hygiene. other then		17. Father's Name (First, Middle, Last)			Chaur.		18. Mothe	er's Name	(First, Middle,		sporta _(ame)	tion
Maryland 21215-0036	2 should be filed w n and Mental Hygie Is marked other t raumatic event, III	To Be	Harry Morton She	wbridge						largaret			
ary	shou ind M inamat umat	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a			I Route Number			Code)
	1 and 2 Health a tem 27 ls		Pamela K. Bailey/d	laughter						SE Cumbe			
ore,	of He fitem		20a. Method of Disposition		20b. Place of Dispos cemetery, crem	sition (Name	e of					n - City or To	
Ĕ	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☒ Donation 5 ☐ Other (Specify)	emoval from State	7	,		´ !					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show eny liquy or other traumatic event, Ite Madical Examiner must be notified at ODCs.		21. Signalure of Funeral Service Licens	ade, Dir	ctor St Ba	Name and ate A ltimo	Address nato	s of Facilit my B MD	oard 2120	655 W.	Balti	more S	treet
	The state of		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do not ente						est,		Approximate
F	Physician		Immediate Cause (Final disease or condition		LATORY	FA	11 1	URE	-			ļ	Interval Between Onset and Death
8	/Medical		resulting in death)		a consequence of):	1 64	16	O ICE					2 WKS
6.50 (c.50)	Examiner		Sequentially list conditions	CONGE	STIVE	HEA	RI	FA	-11-1	IRE			2 1045
1 4	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):	1							
	ecute and -trans	Examiner	that initiated events resulting in death) Last	YNZU	MDN/A	3	YN	18HI	DM;	4			2 WKS
8760,	ate be executed hysician and the burial-transit	ai E				·	0.0	00:	٠.				
687	ate thy the	dicai		INTE	RSTITIAL	- 11	DK	U > 1	7				5 YRS
	death certific e attending p id for use as	Physician/Med	IF FEMALE:	3c. If yes, outcome	of pregnancy					•	224 [Data of dalities	
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at		Ectopic pred						Date of delive Month	Day Year
o	res that the de igned by the a be detached t	nysi	9 Unknown	9□ Unknown			//						
<u>م</u>	s thai	by P	Part II. Other significant conditions con	tributing to death bu	at not resulting in the un	derlying cau	use giver	n in Part I.		23e. Did tob	acco use co	ntribute to th	e cause of death?
Vital Records,	The law requires that the tee has been signed by thoage 2 should be detached.	edk	CERE BROVAS	CULAR	ACCI	DEN	IT			1 □ Y€	s 2 XNo	3 🔲 Prob	ably 4 Unknown
000	aw re	Completed								24a. Was a		. Were autor	osy findings available
ř	The lav	E O								autops perform 1 Yes 2	y ned? !⊠No	death?	npletion of cause of 2 No
<u>ta</u>	ysician: This certificate director, pag	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on		1 1 1 1 1 3	20110
<u>></u>	hysic his ce I dire	2	1 ☐ Yes 2 No	ospital: 1 Inpatie	-	3□ DOA	Other	: 4 □ Nu	rsing Hon	ne 5 🗆 Reside	nce 6 🗆 C	ther (Specify)
Ĕ	ding Pt h. After th funeral	 	27. Manner of Death 1 Manual 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury		c. Injury : Work?			8d. Describe ho	w injury occ	urred	
SIC	tend death tor: / the f	cati	2 Accident Investigation 3 Suicide 6 Could not be	00 00		М		es 2 🗆 l	-				
Division of	l or Al after of Direct I in by	Certification:	4 Homicide determined	building, etc	iry - At home, larm, stre :. (Specify)	et, factory,	office		2	281. Location (Sti City or Town	reet and Nur , State)	nber or Rura	Route Number,
	spite		29a. Certifier Certifying Phys	ician: To the best of	of my knowledge, death	occurred at	the time	, date and	d place, a	ind due to the ca	use(s) and r	nanner as st	ated
	To the Hospitel or Attending Physicien: which 24 hours after deals after deals. To the Funeral Director: After this certification the funeral director, it	edical	(Check only 2 Medical Exeminates)	er: On the basis of and manner sta	examination and/or inv	estigation, ii	n my opi	nion, deat	h occurre	ed at the time, da	ite and place	e, and due to	the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	2 1/		29c.	License	number		29	d. Date sign	ned (Month, L	
,			Mobustiano (1. Bur	rera		D14	865		1	AN.	14 11	2004
			30. Name and address of person who co			,							
			BARRERA, ROBUSTIA	NO J., M.	D., 500 ME	MORIAI	AV	ENUE,	SUI	TE 201,	CUMBI	ERLAND	, MD 21502
2	Sta Registra		31. Date filed (Month, Day, Year) JAN 3 0 2004	32. Registra	ir's Signature	20							
		Melin	JAN 3 V LOUT	A STATE OF THE STA	The last of the la	es.							

the Maryland

death

Baltimore, Maryland 21215-0036

death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Unpend Item#23a, 27, Per ME. G828, 2 Gentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** Month Joseph Francis Sgro III JANUARY 2004 24, 0932 A /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 222 SENECA AVENUE HAVRE dE GRACE HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 79 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 Q M 2 □ F Pennsylvania 206-62-5989 24 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Bel Air Md. Harford Direct 10e Street and Number 10f Zin Code 10g. Citizen of What Country? ŏ United States 1402 Banavie Terrace West 21015 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 2 should be filed within 72 hours after and Méntal Hygiene. Is marked other than "naturei", or ite 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🌣 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cook fast food 12 years 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle: Maiden Sumame) Be ဥ Frances DeLuca Joseph F. Sgro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shi Depertment of Health and Important: If Item 27 is m any injury or other traum. 1402 Banavie Terrace West, Bel Air, Md. 21015 Joseph F. Sgro/father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdns 1/28/04 Bel Air, Md. `4 □Donation 5 © Other (Specify) entombment 22. Name and Address of Eacility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licenses DOCE Þ 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiomegaly **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner tran and that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetaf death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) ☐ Yes 2☐No detached 9 Unknown 9 Unknown signed by it 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1□Yes 2□No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

N Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate 1 ☑ Yes 2 🗆 No if or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 DOther (Specify) AT SCENE 1 TYes 2 □ No မ 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pendina М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OCME JANUARY 25, 2004 Morrie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MXQAAM 31. Date filed (Month, Day, Year) JAN 3 0 2004

KORELL 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001

State

LING

31. Date filed (Month, Day, Year)

LI

JAN 3 0 2004

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10.10

32. Registrar's Signature

			For State Registrar	State of	Maryland /		artment rtificate					jiene	04	02411
	Dharaini		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		Rosalind	C	• · · · · · · · · · · · · · · · · · · ·	S	weitze	r			Januar		004	12:23 p ^M
	Examin		4a. Facility Name (If not institution, g				4b. City, 1	own, or	Location	of Death		4c. Count	y of Death	
2			Heritage Harbo				Anna	1		04 1440			e Aru	
	Funeral Director		5. Social Security Number 577–36–7325	. Sex 7. 1 □ M 2XXF	Age (In yrs. last	birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Year)	Cou	place (State or Foreign
	d.		Usual Residence of Decedent								Nov. 8,	1923	Nor	th Carolin
	yland		10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or items 23s or 28e-f show with the Madical Exac inserment by routified at	Director	MD Anne	Arundel	A	nnap	olis							1 ☐ Yes 2000 No
	or 28	Oire	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?
	ath w		2700 South Have	n Road					401			USA	A	
	tems	Funerai	11. Marital Status	12. Was Deced	es?	13.	Was Decede If Yes, speci	nt of His fy Cubar	spanic Ori n, Mexicar	igin? (Spe 1, Puerto	ecity Yes or No- Rican, etc.)		ce - Ameri ack, White,	can Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏ Yes 2j If Yes, Give Year or Date	ŒNo		1 ☐ Yes 2	∑ No	Specify:			Speci	ity:	White
8	hour	edt	15. Decedent's			6a. Dece	dent's Usual	Occupa	ition			16b. Kind of I	Rusiness/Ir	ndustry
212	n "n	Completed	(Specify only highest	grade completed)		(Give lite.	kind of work DO NOT use	done d retired)	uring mos	t of work	ing	TOD: THING OF	34011100411	, day
212	d with	E	Elementary/Secondary (0-12)	College (1-4		Admi	nistra	tive	e Ass	ista	nt	Mary1a	and S	enate
힏	al Hygi other	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle,			
<u>a</u>	2 should be filed within 72 hours after death with the Marylar and Mental Hyglene. Is marked other then "natural", or items 23e or 28e-f show aumatic event, the Marifield Exist in ermast its multipad at	To	Gideon Creech						R	loset	ta	Uı	nknow	n
a	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailir	ng Address	Street a	nd Numbe	er or Rura	al Route Number	, City or Towr	, State, Zip	Code)
2	and ealth m 27 her tr		Denise Walsh (Da	aughter)					des C		, Arnol	_		
ore e	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from St		of Dispo Itery, crei	sition (Nam natory or oth	of or place)		Date	20c. Location	- City or T	own, State
Ē	. Pag tment tant: jury		*4 □ Donation 5 □ Other (Spe	city)		-	Cemete				/2004 _1	Millers	svill	e, MD
Baltimore, Maryland 21215-0036	permil. Pag Dep. rtment Imp. rtant: I any njury o		21. Signature of Funeral Service Lic	Ch-	_	22	Hard Hard 12 R	esty	y Fun	ieral	Home, e, Anna	P.A. polis.	MD 2	1401
Jiji j			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau ly one cause on eac	sed the death. D	o not ent								Approximate Interval Between
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	- LXammer	<u>.</u>	Sequentially list conditions,	b. 60	10 Nai	<u>y</u>	AM	<u> </u>	d	1ses	e			4.5
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	:e or):	. 11							
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68/	ficate g phy: s the	edic		0.	10010					/	101.7			
Rox	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. Da	ate of deliv	ery
4	death e atte	icia	in the past 12 months?	4 ☐ Pregnar	n 2 □ Fetal dea it at time of death]Ectopic pre] Other (spe					М	onth	Day Year
J.	t lhe by th tache	hys	9 Unknown	9∐ Unknow	n									
	w requires that the de been signed by the should be detached	by F	Part II. Other significant conditions			g in the u	nderlying ca	ıse give	n in Part I.		23e. Did tot	acco use con	tribute to t	he cause of death?
D'C	equir en si ould l	peq	CHOME OF	55/106/1	ve ,	11/1/	NO.06	//	dy	(P)	7 1 Y	s 2 PNo	3 Prot	ably 4 □Unknown
ecords,	as be	Completed									24a. Was a autops		Were auto	psy findings available impletion of cause of
Vital H		Con									perform	ned?/ 2 □ No	death? 1 ☐ Yes	2 □ No
ıta	ysicien: Th	Be (25. Was case referred to medical examiner?					17		of Death	(Check only on	e)		
	Physic this c	ို	1 ☐ Yes 2 Ē-No		atient 2 ER/				4 Linu		ne 5□ Reside			y)
5	ding F h. After funera	ioi:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		Day Year) 285	D. Time of Injury		C. Injury Work		i	28d. Describe ho	w injury occu	rred	
<u> </u>	Mtendi death. ctor: A y the fu	icat	2 Accident investigat 3 Suicide 6 Could not	be 390 Place of	Injury - At home,	form etc	M Cat (act as		es 2 🗆 l		29f Logation (Ct	and and More	han an O	of Courts March on
Division of	l or Attendater death Director: I in by the	Certification:	4 Homicide determine		, etc. (Specify)	iaiiii, str	өөг, гассогу,	onice			City or Towr	, State)	oer or Hura	al Route Number,
	spite ours nerel filled		29a, Certifying	Physician: To the b	est of my knowled	lge, death	occurred a	the time	e date an	d place a	and due to the ca	ausa(s) and m	annar as s	tated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Ex	aminer: On the bas	s of examination a	and/or in	estigation, i	п ту ор	inion, deal	th occurre	ed at the time, da	ate and place,	and due to	the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	. ^			29c.	License	number		2	9d. Date signe	d (Month,	Day, Year)
			Nota	$M.\Delta$				34	19	フタ		1-2	8-2	2004
	5.		30. Name and address of person wh	o completed cause	of death (Item 23a	a) (Type,	Print)		1	, 0	le Re	1 4=	0	1.10 M/
	\		1001 1101	avaku	11 4	00	0 1	Mij.	JS,1	1211	18 14 0	43,	2 3	2004 Dule M
	Sta	_	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	1	4							- 110
	Registr	ar	JAN 3 0 2004	Gamer	19	100	uls							

		•	For State Registrar	State of Maryland / I	Department of Health and Certificate of Death	wientai mygien Reg. N	600	02412
	Physicia		1. Decedent's Name (First, Middle, Last	and the second s	4	2. Date of Death Month	ay Year	3. Time of Death
	/Medic Examin	al .	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat	Sanuary	24, 200 ic. County of Deal	
۲	Examin		Anne Hrundel V	redical Cent	< Hunapolis, M	d H	nne Ar	rundel
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Yrs.	8. Date of Birth (Month, Day, Yea	9. Bin	hplace (State or Foreign
	_	}	Usual Residence of Decedent 10a, State 10b, County	a 10c City Tou	m or Location	Control		10d. Inside City Limits
	Maryla -1 shov	ţŏ	mi) Queen	1	ens ville			1 Yes 2 No
	or 28a	Oirec	10e. Street and Number	1	10f. Zip Code	1	Citizen of What Co	puntry?
	eath w	Funeral Director	11. Marital Status	12 Was Decedent Ever in U.S.	2 G G G		15. Race - Ame	nican Indian,
5-0036	filed within 72 hours after death with the Maryland Hygione ther than "natural; or Items 23s or 28s-f show int, the Medical Exeminer must be notified a	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 (No Specify:	o Rican, etc.)	Black, Whit	
<u>5</u>	72 hours "natural", of call Ex-	eted	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b.	Kind of Business	Industry
1212	y within piene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	NO A		NI	7
and	ed la la	Be	17. Father's Name (First, Middle, Last)	s Schneck	18. Mother's Na	me (First, Middle, Maid	1	emann
Maryland	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	ဥ	19a. Informant's Name/Relationship (T)		b. Mailing Address (Street and Number or R			
	s 1 and 2 if Health if Health item 27 i		Michael Schnede 20a. Method of Disposition	11-a there	of Disposition (Name of	Stevens Date 20c.	Location - City or	0 21666
altimore,	0 0	9.0	1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State cemete	ery, crematory or other place)		ltimore,	
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Does	~~~	22. Name and Address of Facility Hardesty Funera 12 Ridgely Aven	L Home, P.A	•	
t	Title:		23a. Part . Enter the disease or comp shock, or heart failure. List only of	lications that caused the death. Do ne cause on each line.	not enter the mode of dying, such as cardia		20, 10 2	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. EXTREMO	E PREMATURI	TY		2HR DMIN
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	ed sit	liner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			
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58760	cate be physicia the bu	edicai		d				
Box 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3 Ectopic pregnancy		23d. Date of de	
.O.	The law requires that the death certifate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)		Month	Day Year
_	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ords	w require been sig should b					1		robably 4 Unknown
Records,	he law e has b age 2 s	Completed				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
ita	iysicien: The iis certificate ha director, page	Be C	25. Was case referred to medical examiner?			1 Yes 2 X I ath (Check only one)	70 10165	212/10
of <	Physic this ce	ု	1 ☐ Yes 2 No 27. Manner of Death			Home 5 Residence		ocify)
lon	ttending Physical death. ctor: After this y the funeral di	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of Injury at Work? M 28c. Injury at Work? 1 Yes 2 No	1	A	
Division of Vital	i or Attendater deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St		ural Route Number,
_	ospite hours unerel ly filled	Medical Co			ge, death occurred at the time, date and place and/or investigation, in my opinion, death occ			
	To the H within 24 To the Fi complete	Mec	29b. Signature and title of certifier	DO.	29c. License number	29d. [Date signed (Mon	h. Day, Year)
)			> luft on	clair	D0 967	8 1	125	09
			30. Name and address of person who c	ompleted cause of death (Item 23a	, ZOUI Medical PK	ing Anna	epolis 1	18 21401
R.	Sta Regist		31. Date filed (Month, Day, Year) JAN 3: 0 2004	32. Registrar's Signature	Araska))	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kevin Smith 04-00582 State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kevin Thomas Smith Jr. January 21, 2004 1238 A. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical System Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Days 1 M 2 F Director 213-47-7185 04-06-1996 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "netural", or Items 23a or 28a-1 show empty injury or other treumatic event, the Medical Examinal must be notified at once. 1€Yes 2 No Md N/a Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 209 South Monroe Street 21223 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tes 2 Mo 1 ₩wever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A 02 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Kevin Smith Martha Woods 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4119 St.George Avenue Apt3 Robert Jones Baltimore, Md 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 01-28-2004 | Timonium, Md Dulaney Valley Mem. 22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Ave Baltimore, Md 21229 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a 5 moke inhalation /Medical Due to (or as a consequence of): Examiner sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit The law requires that the daath certificate be executed and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? Day 5 Other (specify) à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Shock 1 Nes 2 No Certification; To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28d, Describe how injury occurred fire 28b. Time of 28c. Injury at Work? After Injury 56fm 1 Natural 5 Pending -20-04 1 Yes 2 XNo death. 2 Accident 3 ☐ Suicide investigation after death Director: 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Sp. ify) 28f. Location (Street and Number or Rural Route Number, At home, farm, street, factory, office filled in by 4 - Homicide 20 or John Stately Hurs CE treet within 24 hours a To the Funeral C icai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 XMedicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certil 29d. Date signed (Month, Day, Year) 29cd icense gumber January 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 200 Registrary Signature 31. Date filed (Month, Day, Yade N State 0

DHMH 17 Rev 1/2001

Registrar

Frank David Sadler Unknown 04 04-00647 cm

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

04-026	Please	Type or Print in Bla	ack In	delible Ink.	Ensure	e All Copie	s Are	Legible.	
	. For	State of Maryland	/ Depa	artment of H	lealth ar	nd Mental H	ygiene	2006	021.1
	1 - State Registrar		Cei	rtificate of i	Death		Reg. No	Corne to the state of	J 624 1 3
	1. Decedent's Name (First, Middle, La.	st)				2. Date of D	Death Da	y Year	3. Time of Death
Physician /Medical	Franklin David	Sadler				Januar			1:55 A
Examiner	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of [-	. County of Death	1
	150 S. Willard S	Street		Balti	more			N/A	
Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs. las.	t birthday)	If Under 1 Year Months Days		Hrs. 8. Date of B Min. (Month, L	irth	9. Birth	place (State or Fore
Director	216-92-7768	XM 2□F 40	Yrs.	Monano Bayo	l louis	Sept.	26,		aryland
2	Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Tourn or Lo	nation					10d. Inside City Lim
shove and a	3. 1 37/4	Toc. Oity, I	Balt						1 ☐ Yes 2 🛣
be notified at	10e. Street and Number						40- 0"		
0 99 0		et		10f. Zip Code 21223				izen of What Cou	intry?
I, or tama 23a	11. Marital Status	12. Was Decedent Ever in U.S.	13.1	Was Decedent of H	ispanic Origin	? (Specify Yes or N	10=	14. Race - Amer	ican Indian
un than	1 XNever Married 2 Married	Armed Forces? 1 Yes 2 XNo	10.1	f Yes, specify Cuba	n, Mexican, F	uerto Rican, etc.)		Black, White	
by F		It Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			Specify:	White
yglene. Ner then "nature t, the Medical E	15. Decedent's Ed		16a. Deced	ient's Usual Occup	ation		16b. K	ind of Business/Ir	ndustry
Med m	(Specify only highest gra Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life.	kind of work done of DO NOT use retired	duning mast al d)	working			
di di	12		Cor	ntractor			Re	oofing	
Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Espacified once. To Be Completed by Fur	17. Father's Name (First, Middle, Last)					Name (First, Middi			
To atic		iler			Sop	hie Evely	n Bal	ker	
2 E E	19a. Informant's Name/Relationship (-		or Rural Route Num			
m 27 nar tr	Sophie Evelyn Los					ke Westm			21157
at ite	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State cem	etery, cren	sition (Name of natory or other plac	:е)	01-28-04		ocation - City or T	
Jury jury	* 4 ☐ Donation 5 ☐ Other (Specific			lge Memor					Maryland
ny in	21. Signature of Funeral Service Licer	1500	22	. Name and Addres Ambrose F	ss of Facility uneral	Home of	Lanso	lowne	
= e a	refella	ele .	2	<u>2719 Hamm</u>	onds F	erry Rd.	Lanso	downe, M	
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.			_		arrest,		Approximate Interval Between Onset and Death
sician	Immediate Cause (Final disease or condition resulting in death)	a. Multiple 5+c	ub a	nd cutt	ing u	Jounds			37.50t 47.13 DO4tt
edical miner	resulting in deality	Due to (or as a consequer	nce of):		9				
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nsit n	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 (0. 20 2 00.00400.							
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by the stached	9 Unknown	9 Unknown							
0 0	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco u	use contribute to t	the cause of death?
						1	Yes 2	XNo 3□Pro	bably 4 Unknow
page 2 should						24a. Wa	s an	24b. Were auto	opsy findings availab
age 2						. / per	opsy formed?	dearth?	ompletion of cause of
= 0 o	25. Was case referred to medical				26 Place of	1 Yes Death Check onl		1 A Yes	2 No
W 75		Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatien	t 3 DOA Othe				6X1Other (Speci	, at scen
er a		28a. Date of Injury (Month, Day Year)	Bb. Time of	28c. Injun	/ at	28d Describe	how inur	occurred.	
r: After se funera ation;	1 □ Natural 5 □ Pending 2 □ Accident investigation	Found 1-23-04 For	2451 bmi		L.E.	Suger	was	stabled a	ind aug
by th	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location	(Street an	d Number or Run	al Route Number,
al Diractor: After to led in by the funeral Certification;		Alle	4			Baltin	OFR	IND	willard s
pletely fille edical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam	ysician: To the best of my knowle							
the F	The state of the s	and manner stated.	- array Of HTV			Joodings at the thing			
To the Funeral Director: Att completely filled in by the fun completely filled in by the fun Medical Certificatio				29c. License	number		29d. Dat	te signed (Month,	Day, Year)
1	highi m			0.C	.M.E.		Janua	ary 23,	2004

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINGLI. M.D

JAN 3 0 2004

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylar		artment of H		nd Men		ene@ () (14	02	1. 15
	Physicia	an	1. Decedent's Name (First, Middle, Las						ate of Death Jonth	Day	(e)ar	3. Time	
	/Medic		Mary Louise S						inuary			3:00	РМ м
	Examin	er	4a. Fecility Name (If not institution, give Charlestown Nu			4b. City, Town, o	sville	Death		4c. County of Ball	Ltim	ore	
	Funeral		5. Social Security Number 6. Se		. last birthday)	If Under 1 Year	If Under 24	4 Hrs. 8. C	ate of Birth		9. Birthi	olace (State	or Foreign
	Funeral Director			□M 2\\ F 88	Yrs.	Months Days	Hours	Min. Fe	ate of Birth Wonth, Day,	1915	III	inois	
	, nd		Usuel Residence of Decedent 10a. State 10b. County	10c C	ity, Town or La	ocation					1	10d. Inside	City Limits
	ahov	ŏ	MD Baltin		•	sville							s 20 No
	the N 28a-1	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of Wh	at Cou	ntry?	
	h with	iO je	709 Maiden Cho	oice Lane			21228			U	SA		
	death	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origi	in? (Specify Puerto Ricar	Yes or No-		Amen White,	can Indian,	
0	or it	by Funerat	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🖺 No If Yes, Give		1 ☐ Yes 2X No			,	Specify:		ite	
212-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23s or 28s-f show ent, the MacLical Examitme must be notified at	ed b	15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occup	pation		11	6b, Kind of Busi	ness/in	dustry	
<u>.</u>	nin 72 an' ni Madic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed)	(Give	kind of work done DO NOT use retire	during most o	of working				,	
7 7	filed within Hygiene. other than ent, the M	Com	12	College (1-4or 5+)	t	eacher				educati	.on		
-	0 = 0 \$	Be	17. Father's Name (First, Middle, Last))					st, Middle, Mi e Schw	aiden Sumame, ron kor)		
Maryland	d Mental d Mental narked o	٦ د	Alvin Lemoyne l		10h Madi	ng Address (Street					hto Zie	Codel	
Z Z	d 2 st ith and 27 is n traun		19a. Informant's Name/Relationship (7 Mary Ellen Parks			Fairway l						Code	
ā,	f Heal f Heal item?		20a. Method of Disposition			sition (Name of matory or other pla	ce) l	Date	2	Oc. Location - C	ity or T	own, State	
Ē	Page nent o nnt: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☑ Donation 5 ☐ Other (Specify	Hemoval from State	,,	, , .							
Baitimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Euneral Service Licen Rona Id S	Wade, Directo		2. Name and Addre tate Anat			55 W.	Baltimo	re S	Street	
100	No.		23a. Part Enter the disease, o como	ications that caused the dea		altimore, er the mode of dyn			piratory arres	it,		Approxima Interval Be	ate
÷s.	Physician		shock, ir heart failure. List only of Immediate Cause (Final		NTIA							Opset and	Death
	/Medical		disease or condition resulting in death)	a. Due fi (or as a conse		t						ICA	
¥,	Examiner	L	Sequentially list conditions,	b									
	ed sit	offine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence or):								
	axecu n and al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):						-+		
/60,	death certificate be executed e attending physician and id for use as the burial-transit	icat l		d									
9	certifical anding phy use as th	Medi	IE EEMALE:						AAA	10-1		- 10 - 10 - 10 - 10	
ROX	eath certifi attending i for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Mont							ery Day	Year		
		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify) _							
J.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions co	ontributing to death but not re	sutting in the u	nderlying cause giv	ven in Part I.		23e. Did toba	cco use contrib	ute to t	he cause of	death?
rds,	quires n sigr uld be	ed by							1 🗆 Yes	2 □ No 3	☐ Prol	oably 4]Unknown
ecord	aw require s been sig 2 should b	plet							24a. Was an autopsy	24b. We	ere auto	psy finding	s available
r	The ate h page	Completed							perform	ed? de	ath?	2 No	04450
Vital	sician: Th certificate irector, pag	Be (25. Was case referred to medical examiner?	Hospital:					eck only one				
0	Phys this al di	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpaties 28b. Time o		4 Chauls	7		ce 6 Other		(y)	
	ding After fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2∐N			,,			
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory, office			ocation (Stre	et and Number State)	or Run	al Route Nu	mber,
	rs after el Dire ed in by	Cert		January, etc. (opec	·· <i>y</i> /								
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical		ysician: To the best of my kn iner: On the basis of examin and manner stated.									(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29	d. Date signed (Month,	Day, Year)	
			Mins	J. Name	15	D4	147	48	U	NUAC	7 7	22.	2004
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)	i						
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					·			
	Sta Registi		IMAL O A	2004		South)							

12:05

JANUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Jnaury 15, 2004 Richard Teets 12:05 AMM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Stella Maris Hospice Timonium Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Months Days 1**∑**M 2□ F 55 231-68-9678 Mar 23, 1948 Director Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Item 27 is marked other than "natural; or Items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at MD Prince George's Laure1 1 ☐ Yes 27 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Main Street 20707 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☒ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) is 1 and 2 should be filed withing Health and Mental Hygiene. Item 27 is marked other than steelworker stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rodney Wheeler ဂ္ Josephine Mae Costello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Michaels/sister 997 Salt Mine Road Camp Verde, AZ 86322 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If It any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 \ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Ronal S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 mun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END STAGE LIVER DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Qualto for as a nonsecuance of Physiclan/Medical Examiner physician and the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown certificate has been si rector, page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 😿 No Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending 1 XNatural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / I in by the f 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43725

State

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

JAN 3 0 2004

31. Date filed (Month, Day, Year)

			State of Maryland / D				_	00117
			, FOI	Certificate of			g. No.	UZUI
	Dharini	ŧ	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Danny J. Tamborino			January	27, 2004	2:45 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Tow	m, or Location of Death		4c. County of Death	
	F		4340 Parkside Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	dav) If Under 1 Y	Baltimore ear If Under 24 Hrs.	8. Date of Birth	N/A	place (State or Foreign
41	Funeral Director		1M1 00 F	rs. Months Da	ays Hours Min.	8. Date of Birth (Month, Day,) May 26,	1950 Cou	Canada
	pud *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	Marylk faho	ĮO.	Maryland N/A		timore			1X Yes 2 □ No
	r 28a	Director	10e. Street and Number	101. Zip Coo		10	g. Citizen of What Cou	intry?
	23a c	aiD	4340 Parkside Drive		21206		Canada	lo.
	er des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent If Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinar most by rudified at once.	by	1 M Never Married 2	1 ☐ Yes 2💢	No Specify:		Specify:	Vhite
Maryland 21215-0036	72 hor	Completed	15. Decedent's Education 16a. [(Specify only highest grade completed)	Decedent's Usual Oc Give kind of work do	ccupation	cina 10	6b. Kind of Business/Ir	ndustry
7	within ne.	mple	Elementary/Secondary (0·12) College (1-4or 5+)	life. DO NOT use re	etired)		T T 11 1	
N	filed v Hygie ther t		12th Grade 17. Father's Name (First, Middle, Last)	Housing 1		e (First, Middle, Ma	FEMA	
an	ld be lentat ked o	To Be	Joseph Tamborino			z Unknown	,	
ary	2 should and Men ts marks	-		Mailing Address (Sti	reet and Number or Rur			p Code)
	and 2 eaith m 27				de Drive, B			
20	Pages 1 nent of H nnt: If Ite iry or ott		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery.	Disposition (Name of crematory or other	place)		Oc. Location - City or T	
altimore,	artmer ortant injury		*4 □ Donation 5 □ Other (Specify) Bayviet 21. Signature of Funeral Service Licensee □	v Cremato			Baltimore, Funeral Ho	
Ba	Departi Departi Import any inj	J.	Mill & Baylams		ehms Lane,			
Н	*		23a. art1. Enter the disease, of complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	t enter the mode of	dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
ı,	Physician		Immediate Cause (Final disease or condition resulting in death) a. Utility Special Special Constitution and	l None	Hodg Kin.	5 Lynn	shoma	Onset and Death
В	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	i di	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury):				
	cuted nd ransit	Examiner	that initiated events C.					
760,	te be executed sician and e burial-transit		resulting in death) Last Due to (or as a consequence of	i:				
687		dical	d					
Box	leath certificate h attending physical I for use as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of deliv	ery
	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 Yes 2 No 1 Ves 2 No	3 □Ectopic pregna 5 □ Other (specify			Month	Day Year
o.	d by the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in	ha madashisa sana		220 Did toho	cco use contribute to t	ha course of death?
Vital Records,	w requires that the de been signed by the should be detached	d by	Part II. Other significant conditions continuiting to death but not resulting in	ne underlying cause	given in Part I.	1 □ Yes		bably 4 Unknown
CO	w requ	Completed				24a. Was an	24b. Were auto	opsy findings available
Re	The lay te has age 2	omp				autopsy performe	prior to co death?	impletion of cause of
ıta		Be C	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 2 ☐ h (Check only one)		Z No
<u>></u>	hysic his ce	10	examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outp		-	ome 5 Presiden	ce 6 Other (Specia	(y)
Division of	ding P		Elitable 5 I origing		njury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
/ISIC	Attendent death	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)				et and Number or Run	al Route Number,
	s after of Dire	Certification:	4 Homicide building, etc. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, to	edical (29a. Certifier (Check only (Ch	death occurred at the	e time, date and place, ny opinion, death occur-	and due to the cau	se(s) and manner as s e and place, and due t	stated. o the cause(s)
	thin 2 the l	Med	one) and manner stated. 29b. Signatur, and title of certifier	29c. Lic	ense number	290	d. Date signed Month,	Day, Year)
•			Daty Water Lung, h.D.	D(9559	1	128/04	
	2	1	30. Name and address of person who completed cause death (Item 23a) (T	ype, Print)	2 (2)	. 1 /	5, - 1.	
			LARRY WATERIZURY, MID JAB	he 40		EN AUE.	NALI. ROD.	21224
	Sta Registr	-	31. Date filed (Month, Day, Year) 32 Registrati Signature	B. Again				
			e ⁻	All				

Baltimore, Maryland 21215-0036

Phy: /Mc Exa

Division of Vital Records, P.O. Box 68760,

700		For Amended Item#1	State of Maryla	and / Depa	artment of H	lealth and M		3	02418	
		1 - State Registrar Unpended Item#. 1. Decedent's Name (First, Middle, Last)	23a,27,28a-f,P	er ME,682	gj <i>iipatpool</i> g	Death	2. Date of Death		3. Time of Death	
Physici /Medic		William John T.	ress, Sr.				Month JANUARY	27,2004	5:10P. M	
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death	-	4c. County of Dea		
		331 E.25th STREET			BALTI	MORE		N/A		
Funeral Director		213-18-4244	7. Age (In y 44	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10, 10)	(ear) 9. Bi	rthplace (State or Foreign ountry) LYLand	
and *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ncation				10d. Inside City Limits	
fanyli sho	5		100.	-					1 ☑ Yes 2 ☐ No	
the A	ect	Maryland N/A 10e. Street and Number			Baltimor 101. Zip Code	e	100	g. Citizen of What C		
with Ba or	0	331 E. 25th Stree	<i>†</i>			21218	10	u.s.A.	ountry !	
ms 2:	Funeral Director		2. Was Decedent Ever in	U.S. 13.1			ecify Yes or No-	14. Race - Am	erican Indian.	
or Ite	F.	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💢 No			lispanic Origin? (Spo an, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.	
ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🗓 No	Specify:		Specify: (Vhite	
72 h	Completed by	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup	during most of work	ina 16	6b. Kind of Business	/industry	
within ne.	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	a)				
lied v tygie ther t	ပိ	11th Grade 17. Father's Name (First, Middle, Last)		Mai	ntenance	10. Mathada Nama	/First 841-date 84	Contracto	けた	
ntal hed of	Be		ress			18. Mother's Name		hefsky		
hould d Me mark matic	은	19a. Informant's Name/Relationship (Type		10h Mailic	o Address (Street			City or Town, State,	7:- C-d-)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic svant, the Medical Examinar must be notified at once.		Mr. Michael Tress	(brother)			tone Driv			21237	
Hea Hea tem		20a. Method of Disposition		. Place of Dispo	sition (Name of	Ţ		c. Location - City or		
Pages nent of I nnt: If Its ury or o		1 ☐ Burial 2 💢 Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory`or other plac Crematori			ltimore,		
artm. Fortar		21. Signature of Funeral Service License						neral Hon		
Depa Impo sny ii		Jam Ma						MD 2123		
11/4		23. Part1. Enter the disease shock, or heart failure. List only on	cations that caused the de						Approximate	
Physician	8	Immediate Cause (Final	Narcotic Int	_					Interval Between Onset and Death	
/Medical		disease or condition resulting in death)	Due to (or as a cons							
Examiner		Convention to the same distance								
D ==	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of						
ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
9 .9 5	ũ	resulting in death) case	Due to (or as a cons	equence of):						
death certificate be attending physic	dlcal	d.								
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atten for u	ian	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
at the de by the a tached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	i dealii 5	Other (specify)					
The law requires that the death certificate at the has been signed by the attending physpage 2 should be detached for use as the		Part II. Other significant conditions cont	ributing to death but not r	esulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?	
quires that n signed t	d by						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 🛣 Unknown	
s been s shouk	Completed						24a. Was an	24b. Were au	itopsy findings available	
The lav	E						autopsy	d? prior to death?	completion of cause of	
	0	25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 A Yes	2 No	
Physical this cerral direc	To B	examiner? 1 □∰es 2 □ No Ho	ospital: 1 Inpatient 2	☐ ER/Outpatrent	t 3□ DOA Othe			ce 6 🖾 Other (Spe	city)SCENE	
ng Pt fter th neral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury TOLING oth, Day Year)	28b. Time of	28c. Injun	at 2	28d. Describe how	injury occurred	7,00000	
endii eath. or: A he fu	atic	2 Accident investigation	1/27/04	5:05		Yes 2 ₹ No	unkno	OWIL .		
or Att	Certification:	3 ☐ Suicide 6 ♣ Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, office	2	City or Town, 5	et and Number or Ru State)		
Hospital or Attending Physician: 24 hours after death. Funeral Diractor: After this certificitely filled in by the funeral director,		00- Coding ACI Codition Bt	other residen				DALL IMOTO	h Street,1s		
Hosp 24 ho Fune stely f	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my of	ie, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and dua	stated. to the cause(s)	
To the Hospital or Attending I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Monta	h, Day, Year)	
->- o		I his his.	MID			C M E			,	
	1	30. Name and address of person who con		em 23a) (Type. F		C.M.E.	JAI	NUARY 28,	2004	
		LING LI M				Street, B	altimore	, Marylan	d 21201	
³⁵ Stat		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature «	1					
Registra	ar	JAN 3 0 2004	Se sera	16) pt	porks					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month Dev **Physician** 6:20 a.m. 2004 hommen 23. January /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Rosedale Baltimore Co. Franklin Woods Nursing Home If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours 1□M 2K0F Yrs. 97 212-48-9552 21, 1906 Maryland Director Aua Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryla Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturel", or Itam 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 ¥☐ No Director Sparks Maryland Baltimore Co. 10g. Citizen of What Country? 10f. Zip Code 10e Street end Number 21152 United States 16417 Cedar Grove Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritel Status 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☒ No altimore, Maryland 21215-0036 Specify: White 2 3 X Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 yrs. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be C1ubb ည 0'Connell Laura 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 245 Rachel Circle Forest Hill, Maryland 21050 Mr. Robert J. Thommen / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/26/04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 21. Signature of Funeral Service Licenşee 22. Name and Address of Fecility William G. Dau 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attanding physician and for usa as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Last signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? To the Hospital or Attanding Physician: The law within 24 bours after death.

To the Funeral Director: After this certificate has it completely filled in by the funeral director, page 2 s 2 No 1 ☐ Yes 2 ☐ No 1 Tyes Hospital or Attanding Physician: 24 hours after death. 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Death Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Critifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted. Medical 29a. Certifier 29c. License numbe 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifie

State Registrar om Edmondson

31. Dete filed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32 Registrar's Signature

10	Physici /Medio		1 - For Amend Item 26 per Registrar 1. Decedent's Name (First, Middle, Last) Donna			alentine		2. Date of Death Month January	1	2004	3. Time of Death 03:40 A M
	Examir	2. 45	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Glen Bur	Location of Death		4c. County Anne		do1
	Funeral Director		300 Phe1p Avenue 5. Social Security Number 218–42–0644 1	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 9,			place (State or Foreign
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru		City, Town or Lo Pasaden			7			l0d. Inside City Limits
	n with the 3a or 28e	al Director	10e. Street and Number 16 N. Carolina Ave	nue		10f. Zip Code 21122		10	g. Citizen of \	What Cou	ntry?
036	72 hours after death with the Maryland "naturel", or flems 23a or 28e-1 show clost Exertine mant be rediffed at	by Funeral	11. Marital Status 1 Never Married 27 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba □ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blad	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	within ene. than *	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired Superviso	luring most of work)	ring	-		of Motor
lana ,	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) John Harvey Caves				18. Mother's Name	Reynold:	laiden Suman		
	d 2 sho th and 7 Is m treum	i	19a. Informant's Name/Relationship (Type Mr. Oris Valentin			g Address (Street a		al Route Number, Pasadena		State, Zip	_
Baitimore,	Pages nent of ant: If if		20a. Method of Disposition 1 ABurial 2 Cremation 3 R 1 Donation 5 Other (Specify)	emoval from State Ma	ryland	Veterans	⁹⁾ Jan 2 2004	O C:	oc. Location -	ille,	MD
Dai	permit. Pag Department Importent: I any injury o		21. Signatur, of Funeral Service License	Moreso	1_	. Name and Addres Second Av	renue SW	Glen Bu	rnie, N		e, P.A. 1061
	Tiysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the de the cause on each line. Variation Due to (or as a conse	an (er the mode of dying	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onse, and Death
	M Dec	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
68/6 0,	ficate be executed physicien and is the burial-transit	edical E	d								
P.O. BOX	death certi e attending ed for use a	Physiclan/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown 23d. Date of Month 2 Month 2 Month 2 Month 2 Month 2 Month 3 Month 2 Mon								ery Day Year
	law requires that the as been signed by th 2 should be detache	by									ne cause of death? ably 4 □Unknown
or vital Records,	The ate h page	Completed						24a. Was an autopsy perform.	ed?	prior to cou death?	psy findings available appletion of cause of 2 No
or vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2/5 No H	lospital: 1 Inpatient 2 [☐ ER/Outpatien		r: 4 ☐ Nursing Ho	me 5 Residen 28d. Describe hov	nce 6 Oth	er (Specif	Sister Residence
UNISION	or Attending after death. I Director: After d in by the funer	Certification;	Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At	Injury home, farm, stre		res 2 □No	28f. Location (Stre	eet and Numb		I Route Number,
วิ	- 9.5		29a. Certifier 1 Certifying Phys	building, etc. (Spec	nowledge, death	occurred at the tim	e, date and place,	City or Town,	use(s) and ma	nner as si	ated.
	To the Hospitel o within 24 hours aft To the Funerel Di completely filled in	Medical	29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	7. 1	29c. License			d. Date signed		
			30. Name and address of person who co	· Ilon · a no	em 23a) (Type,	Print) Fronte	Ly 50 6	ospital C	to, c	3/	6,200 y
€	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	y ore for a	J 38.	Golf 1	hel d	123	2

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MELVIN 51 WILLIAM WILDER 19mpm 23 2004 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/31/1918 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Hours Months XXM 2 F Director 214-03-3122 85 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits parmit. Pagas 1 and 2 should be filed within 72 hours aftar daath with tha Merylan Dapartment of Haaith and Mantal Hygiena. Important: if item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 💥 🗓 No Funeral Director ANNE ARUNDEL GLEN BURNIE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1005 STANE ROAD 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Merital Status 1 ☐ Never Married 2 Married TYYES 2 □ No. Yes, Give WWTT 1 ☐ Yes 2 No WHITE Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CARPENTER HENRY KNOTT CO. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE W. WILDER MARGARET BOOTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNETTE W. WILDER - WIFE 1005 STANE ROAD, GLEN BURNIE, MARYLAND 21060 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Kurial 2 ☐ Cremation 3 ☐ Removal from Stete MORELAND MEMORIAL PARK 1/27/04 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 KELLY GREGORY FINK #M01148 Approximate Interval Between Onset and Death Enter the diserse, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician Immediate Ca e (Final disease or condition resulting in death) /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? KINU 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA this (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel daath. 1 ☐ Yes 2 ☐ No Director: A 6 Could not be determined 3□ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide within 24 hours of To the Funeral D complataly fillad i edicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the (Check only Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 min 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 0 31, Date filed (Month, Day, 32. Redistrar's Signature

State Registrar

DHMH 16 Rev 6/95

04-00693 DAN N WELLS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Unpended Item#23a,27,28a I, Fer ME, 328,27,348 (Pended Item#23a,27,28a I, Fer ME, 328,27,348) WHM 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** JANUARY Wells 24, 2004 Dan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMOER CO E B ROUTE 40 @ PATAPSCO RIVER BRIDGE ELLICOTT CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 100 M 2□F 267-84-8252 Feb. 1951 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 7 is marked other than "naturel", or Items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Director MD Howard Ellicott City 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 8958 Town & Country Blvd. 22043 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Groundskeeper Community Association 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) Be John Dearborn Wells Marjorie Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8958 Town & Country Blvd., Ellicott City, MD 22043 Denise Wells (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1/30/2004 Metro Crematory Baltimore, MD 21. Signature of Europral Service Ligensee 22. Name and Address of Facility Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 alr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Multiple Injuries Physician /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? õ 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown à signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, edical Certification: To Be Other: 4 Nursing Home 5 Residence ther (Specify) SC + NE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 □ No this 28a. Date of Injury 1/24/04 Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 🛭 Pending Injury or Attending 1 Natural subject precipitated from bridge vithin 24 hours after death.

To the Funerel Director: After completely filled in by the fun. unknown 1 ☐ Yes 2 VINo investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) BRL-400Patapeaco River Bridge 6 Could not be 3X Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide The function of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hospitel 29a. Certifier (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 25, 2004 OCME Whome

State Registrar

KOREU 32. Registrar's Signature men

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PYDOUN

JAN 3 0 2004

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

3. Time of Death

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Dav

3 Probably 4 Unknown

1 X Yes 2 □ No

Florida

<u>6:40</u> ₽[™]

Year

0

	1 - For State of Maryla	-	artment of Hea rtificate of De		Re	g. No.	04 024		
Physician	Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of I		
/Medical	Jazmine Mercedes Wells				January	21, 20	04 12:41		
Examiner	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Loc			4c. County of	Deeth		
	University of Maryland Medical		Baltimor	C Under 24 Hrs.	0.5		/A		
uneral irector	1□M 25€	rs. last birthday) Yrs.		lours Min.	8. Date of Birth (Month, Day,	Year) 9	Birthplace (Stete or Country)		
rector	215-53-2740 5				08-18-19	98	Maryland		
MO W	10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City		
d other than "natural", or items 23s or 28s-f show svent, the Medical Examiner must be notified at Be Completed by Funeral Director	Md N/A	Baltim	ore				1 € Yes		
te retified be retified Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	at Country?		
is is	209 South Monroe Street		21223			U.S.A.			
drar must Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of Hispar of Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.		
F Y				pecify:			Black		
el Exe	3 Widowed 4 Divorced Year or Dates:	100 0			1.				
r, the Medical E	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of worki	ng 1	6b. Kind of Busin	ness/Industry		
E G	Elementary/Secondary (0-12) College (1-4or 5+) Kindergarden	<i>M</i> 6. 1	N/A			N/	٨		
C ar				Mother's Name	(First, Middle, M		A		
c svs						•			
matic sv	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and I		e Bernet		ate Zin Code)		
other trsumatic	Robert Jones		St. George						
othe		D. Place of Dispo	sition (Name of natory or other place)			Oc. Location - Cit			
	Tabounal 2 Clemation 3 Helitoval Iloni State	cemetery, cren Julaney		01-28	3-2004	imonium	Ma		
iniu	21. Signature of Funeral Service Licensee		Name and Address of						
enporant: II	1 (m) 121. had		00 S. Beech						
35	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.						Approximate Interval Between		
te burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dise to (or as a consequence of): C. Due to (or as a consequence of):								
detached for use as the	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnant at time of the pregnant at tim		23d. Date of delivery Month Day Year						
should be deta	Part II. Other significent conditions contributing to death but not i	esulting in the ur	nderlying cause given in	Part I.	23e. Did toba	cco use contribu	ite to the cause of dea		
d by					1 Tes	2 No 3[Probably 4 Uni		
shor.					24a. Was an	24h Wor	e autopsy findings av		
r, page 2 should					autopsy perform 1 Yes 2	od? deat	r to completion of cau		
director, pag	25. Was case referred to medical examiner? 1 ▼ Yes 2 □ No	Celerate	04		Check on one				
	1 X Yes 2 No No Nospital 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ZER/Outpatient 28b. Time of	28c. Injury at		ne 5 Residen		Specify)		
tunera tion:	1 Natural 5 Pending 2 Accident investigation (Month, Day Year)	Injury	PM 1 □ Yes	. 1	subject	in ho	use Fire		
I in by the fu ertificati	3 Suicide 6 Could not be 28e. Place of Injury - Al	home, farm, stre		2	8f. Location /Stre	et and Number o	or Rural Route Numbe		
erti	4 Homicide building, etc. (Spe	city)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ć	Of or Town	Statelly M	on soe Sh		
completely filled in by the funeral Medical Certification:	29a. Certifier (Check only (C	nowledge, death	occurred at the time, da	ate and place, a	nd due to the cau	Se(s) and manne	or as stated		
completely filled in by the t	and marrier stated.								
00	29b. Signature and title of certifier	200	29c. License nun			I. Date signed (M	**		
	Tolulione to	leka	2	O.C.M.E		anuary	22, 2004		
	30 Name and address of person who completed cause of death (II	/							
	FATRICIA MODICA-POLLAK		nn Street,	Baltimo	ore, Mary	land 21	201		
State Registrar	31. Date filed (Month, Day, Year) 32. Registration Sign		Last :						

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Marie H. Whaley 27, 11:50 AM January 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ivy Hill Geriatric Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K) F 96 Yrs. Maryland Director 214-01-6222 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Baltimore [] 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 3330 Edwars Lane 21220 death Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ö White 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 X Divorced natural', 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) R Food Server Calvert Distillery other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fill of Health and Mental Hy I item 27 Is marked oth Be Louis V. Kahmer, Sr. Elizabeth Ann Plock ೭ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha E. Deck Daughter 3330 Edwards Lane, Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State o = 1 ABurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 1-30-2004 Baltimore, MD permit. 21. Signature of Euneral Service Licensee 22. Name and Address of Fattobrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beath Immediate Cause (Final **Physician** Want resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and I for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 € No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2) No P 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of tnjury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. s after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide wit in 24 hours af To the Funeral D con pletely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 761 31. Date filed (Month, Day, Year) 32. Registra 's Signature State Registrar JAN 3 0 2004

			For State Registrar	State of N	Maryland / De	epartment Pertificate				giene	04	02425
	Dharaini		1. Decedent's Name (First, Middle, L						2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		NORMAN						JAN		2004	1-49 pm
1	Examin	er	4a. Fecility Name (If not institution, g.				own, or Location		075	4c. Coun	ty of Death	
			UNIVERSITY OF									
	Funeral			Sex 7 1 1 3 M 2 ☐ F	Age (In yrs. la <i>st birtho</i> 77 Yr:	Months	Days Hours	Min.	8. Date of Birt (Month, Da)	v, Yeer)	Coun	**
	Director	-	Usual Residence of Decedent		//				lov. 7,	1926	Dela	ware
	lend **	Ì	10a. State 10b. County		10c. City, Town o	or Location					10	Od. Inside City Limits
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	r 28a	ě	10e. Street and Number			10f. Zip C				10g. Citizen of	f Whet Coun	try?
	h with	Funeral Director	214 Thompsonvil	le Road			19963			United	State	Q
	de de	Je.	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was Decede	ent of Hispanic (Origin? (Spec			ace - America	an Indian,
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	Hygie ther int,	ပ္	17. Father's Name (First, Middle, Las			Truck	Driver		(First, Middle,		nsport	ation
an	d be antal	9 Be	Ralph R. Webb	,			El	izabet	h Shor	r		
Maryland	permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylen Deperment of Heelth end Mantal Hygiene. Importants if Item 27 is marked other than "natural; or Iteme 23a or 22a-f show any lojury or other traumatic avent, the Macical Exemination must be notified at once.	၉	19a. Informant's Name/Relationship	(Type, Print)	19b. N	failing Address (n, State, Zip	Code)
Σ	trau		Patricia Ann We									
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٥	ages ant of it: if i		1 ☐ Burial 2 ☼ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Melson'	crematory or other		1-26-	2004	Frankf	ord 1)F
Baltimore,	ertme ortar		21. Signature of Funeral Survice Lice		1/2 01		Address of Fac					
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			23a. Part1. Enter the disease, or co	mplicetions that caus	ed the death. Do not	enter the mode	of dying, such a	as cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician	-	shock, or heart failure. List onlinediate Cause (Final	-		UE N	LEART	- =4	11 101	=		Onset and Death
1	/Medical		disease or condition resulting in death)	Due to for	4 F E ST (-	70.11.0
	Examiner			. CR	TICAL	AOR	TIC	STE	MOZI	2	r	MONTHS
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9 ×	leath certificete ettending phys I for use es the	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcon	an of pregnancy	11.7	77	1 10 6 50				
Вох	etter for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 ☐ Fetal death at time of death	3 ☐Ectopic pre-					ate of deliver fonth	y Day Year
	9 9 2	S	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		3 □ Other (spe	y)			į.		
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Division of Vital Records,	hes je 2	E	- CAPACITE TO THE PARTY OF THE	ICEMAL) ICMMS	PLAN	4.)		autop	sy med?	prior to con death?	pletion of cause of
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	To the Hospitel or Attending Ph within 24 hours elter death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying F	Physician: To the be	st of my knowledge, of examination and/o	leath occurred a	t the time, date	and place, ar	d due to the d	ause(s) and m	nanner as sta	ited.
	ths H in 24 ths F aplete	led	one)	and manner	stated.							
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	A		30. Name and address of person wh			rpe, Print)		0.0		Ma 'm A		BALTIMORE
			GEORGE BAFA	-0E-B	ONNIE,	VNIV	- UF M	MKYL	AND	men	CIR. 1	J M -1111 ORE
	Sta Registr		31. Date filed (Month, Day, Year)	, ,	strar's Signature	CONTRACT F						
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Day Year **Physician** elen Wentz 2001 2:00 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□√F Days 219-07-2027 84 May 21. Director Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Heelth and Mantel Hygiene. Imprortant: if them 27 is marked other than "natural", or thems 23s or 28s-f ahow any Injury or other traumetic event, if a Medical Examinar must be not the 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo Funeral Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 508 Parksley Ave. 21223 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritel Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Social Security Elementery/Secondary (0-12) College (1-4or 5+) Social Security Administration 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Carl David Jung Mary Holmes 19a. Informant's Name/Relationship (Type, Print)
Sandra Langley, daughter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 113 Circle Rd. Pasadena, MD. 21122 20b. Plece of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 01-28-04 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Holamay Geass Examiner Due to (or es a consequence of) Completed by Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tunknown deorente 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? atrial Pitrillation 1 Yas 2 746 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Nature 5 Pending 1 Tes 2 No investigation within 24 hours after deeth. To the Funeral Director: A 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. completely (Check only To the 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier 1219667 au and 01-26-2004 Millare

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State Registrar 31. Dete filed (Month, Dey, Year)

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me and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

2004

32 Registrer's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wilma Ann January 28204 Yeager /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Grace ng Home 8. Date of Birth (Month, Day, Year) 1117en 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1□M 2√F 212-03-3272 83 Yrs. Maruland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 71e marked other than "natural", or Items 23e or 28e-f show treumatic event, the Neulcal Exercities must be notified at 1 ☐ Yes 2 No Maryland Harkord Directo Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 720 Beretta Way U.S.A. 21015 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ent of Health and Mental Hygiene. In: if item 27 le marked other than "natural; or lite iny or other treumatic event, the Neulical Estactive 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Credit Union 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Jung Teresa Hude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 720 Beretta Way, Bel Air, MD Mr. John C. Yeager (husband) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State permit. Pages Department of Importent: If it any injury or o Bayview Crematory 2/2/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dehydral Physician cn k /Medical Due to (or as a consequence **Examiner** al Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year jo in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) cate has been signed by the case 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No certificate After this certification funeral director, I 25. Was case referred to medical 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospitel or Attending 5 Pending investigation Division 1 Natural within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifierin 132609

Registrar

reager. Wilma

32. Registra & Signature

1106 Revolution St

Harre De Grace MM 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kamneden Melhani MD

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

*			State of maryland	Certificate of De	eath	Reg. No.
			Decedent's Name (First, Middle, Last)		2. Date of Dea	
	Physici /Medi		James Madison Allen		Jamor	
)	Examir		4a Facility Name (If not institution, give street and number)	4b. C	City, Town, or Location of Death	4c. County of Deeth
		в	Harbor View Hospital		Baltimore	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days H	Under 24 Hrs. 8. Date of Birt (Month, Da) May 1,	h 9. Birthplace (State or Foreign Country)
	Director		212-36-0492	Yrs.	May I,	1940 North Carolina
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Town or Location		10d. Inside City Limits
	fanyls ed at	5				1 □ Yes 2√TXNo
	28a-	Director	Maryland Anne Arundel Gl	en Burnie		10g. Citizen of What Country?
	¥ o d		7769 Overhill Road	21060		U.S.A.
	eath	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.		anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	
_	fter d	튑	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No			Black, White, etc.
8	urs a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Sį	Specify:	Specify: White
Ö	n 72 hours after death with the Maryland "naturel", or Hems 23e or 28e-f show edical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	n na most of working	16b. Kind of Business/Industry
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nd	be file of oth	Be	17. Father's Name (First, Middle, Last)		. Mother's Name (First, Middle,	
Z	Ment Ment	၉	Francis Southworth Allen, II		Mary Elizabeth	
la l	and and the me	- 1		19b. Mailing Address (Street and		
~	end ealth m 27	- !		7769 Overhill R		e, MD 21060 20c. Location - City or Town, State
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other treumatic event, the MORGE.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Disposition (Name of netery, crematory or other place)	Date	
Ē	Pant:)		rside Cemetery	1/15/04	North, SC
Sal	Departiment mport		21. Signature of Funeral Service Licensee	22. Name and Address of Culler-McAl	of Facility .hany Funeral H	ome
	70 = 4 a		Lennes Fellmein	P.O. Box 96	, North, SC 29	112-0096
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, so	such as cardiac or respiratory ar	interval between
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-	death le atter	Cla	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in	n Part I. 23b. Did t	obacco use contribute to the cause of death?
P.0	v requires that the death ce been signed by the attendi should be detached for use	Physician/		ig in the enterlying sector given in		Yes 2 No 3 Probably 4 Unknown
_	s tha	by P				
ğ	requires seen sign should be	8				an autopsy 24b. Were autopsy findings available prior to
S	law re las bee	plet				completion of cause of death?
æ	0 - 0	Completed			101	res 2 No 1 Yes 2 No
of Vital Records,	ilclan: The certificate rector, per	Bec	25. Was cese referred to medical	26	6. Place of Death (Check only o	ne)
>	S 0 0	2	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER	R/Outpatient 3□ DOA Other:	4 ☐ Nursing Home 5 ☐ Resid	dence 6 □Other (Specify)
0	ding Ph h. After th funeral		27. Menner of Death 28a. Date of Injury 28 (Month, Day Year) 28	Bb. Time of lnjury at Work?	28d. Describe	now injury occurred
Ö	Attending in death. Sector: After by the fune	atic	2 Accident investigation	M 1 ☐ Yes	s 2□No	
Division	l or Attend efter deeth Director: / d in by the i	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, efc. (Specify)	a, farm, street, factory, office	28f. Location (S City or Tox	Street and Number or Rural Route Number, vn, State)
Ω	urs ef	ပီ				
	To the Hospital or Attending Phy within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier TG Certifying Physician: To the best of my knowle (Check only one) And manner stated.			
	ithin it	Me	29b. Signature and title of certifier	29c. License nu	umber	29d. Date signed (Month, Day, Year)
	S S S S S S S S S S S S S S S S S S S		Dan Inna	DLAZO	977	Transpore 9 DANA
			30. Name and address of person who completed cause of death (Item 23	3a) (Type Print)		in with acoup
			On the and address of person who completed cause of death (item 2	AN DELINE, le	bustandina.	WD 2106/
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	· 4 /- //	· · · · · · · · · · · · · · · · · · ·	· · · · ·
	Regist		IAN 1 5 2004 Deput	D BHOURS		

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day James E. Allen January 11, 2004 7:24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 217-07-3144 Director 88 Sept. 15, 1915 Florida Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or the Medical Examiner must be 2400 Henslowe Drive 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces:
1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: WW II within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: ģ Specify: 3 Widowed 4 Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Wholesale College (1-4or 5+) Chairman of the Board **Pharmaceuticals** marked other other traumatic avant, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avant once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Horace J. Allen Miriam E. Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reid F. Allen/Wife 2400 Henslowe Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 21, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sylvan Abbey Memorial Park `4 □ Donation 5 □ Other (Specify) 2004 Clearwater, Florida 21. Signature of Funeral Service Vicensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 0 Tax 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 1 Yes 2☑ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 25 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending s after de. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5+1 January 13, 2004 1) 60557 lo shu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shue Leo 9901 Medical Center Drive, Rockville, Maryland 20850 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State JAN 16 2004 Registrar

			For State Registrar	te of Maryland		rtment of He			ene20	04	02430	
	P	-4.	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death	
	Physicia /Medic	⊸	June A. Aloi					January	14, 2	004	3:45 PM	
i e	Examin	_	4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, or			4c. County of Death			
			14 Sherman Avenue			Takoma	Park If Under 24 Hrs.	D. D. L. of Birth		gome	-	
	Funeral		5. Social Security Number 6. Sex 1 M 25	7. Age (In yrs. las. 74	t birthday) _ Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, June 18,	Year)	Cou		
	Director		Usual Residence of Decedent	74				Julie 10,	1323	rial	land	
	yland now		10a. State 10b. County	10c. City, 1	Town or Loc	ation					10d. Inside City Limits	
	Mar a-fet	tor	Maryland Montgomery	Tak	oma P	ark					1⊠Yes 2 No	
	or 28	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of		ntry?	
	ath w		14 Sherman Avenue				912	N	USA 14. Race - American Indian,			
	lterne	Funerai	Am	s Decedent Ever in U.S. ned Forces?	13. W	Vas Decedent of His Yes, specify Cubar		ck, White,				
50	e filed within 72 hours after death with the Maryland if Hygiene. other than "naturel", or lieme 23e or 28e-f ehow other than "naturel", or lieme 23e or 28e-f ehow ont, the Medical Enaminer must be motified at	by F]Yes 2⊠ No es, Give arorDates:	1	☐ Yes 2☑ No	Specify:		Specia	y:Whit	e	
ş	2 hou	ted	15. Decedent's Education		16a. Deced	ent's Usual Occupa	6b. Kind of B	lusiness/In	dustry			
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Maryland 21215-0036	ed wit	Col	12		Nur				Medi			
	0 20 0	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M				
<u> </u>	75 5 C (1)	ဥ	Guy Ward	net)	10b Mailin	g Address (Street a		Catherin			Code)	
ā	d 2 sho		19a. Informant's Name/Relationship (Type, Pri. Paul Aloi/ Son			Thompson					7 0000)	
20	os 1 and 2 should of Health and Me I Item 27 ie mark r other traumation		20a. Method of Disposition	20h Plac	e of Disnos	sition (Name of	1 -	Date 2	0c. Location		own, State	
<u>ē</u>	ages ant of nt: If It		1 ☐(Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	I from State Mou	nt 01:	ivet vet	Janu Janu	ary 19 004	Washi	ngton	, DC	
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny injuryor ot		21. Signature of Funeral Service Licensee		Cemete	Name and Addres				-		
ñ	Ped die		Anne Marie,	Er/ces	50	o Univers	sity Blv	d. W., Si	lver S	inc. Sprin	g, MD 20901	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		rdia	1 in fac	rction				Onset and Death	
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	Examiner		Sequentially list conditions, b.	Oue to (or as a conseque	1 cer	teny a	1 seatt				7 cars	
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/60,	Attending Physician: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physicien and settor: After this certificate be as been signed by the attending physicien and by the funeral director, page 2 should be delached for use as the buriat-transit	icai E	L _d									
89	tificati ng phy as the	ed							1			
ROX	attending for use a	Physiclan/M	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy						23d. Date of delivery Month Day Year		
	ed for	sicla	1 ⊔ Yes 2/24N0	Pregnant at time of dea Unknown		Other (specify)			141	ontri	Day 16a1	
J.	at the	Phy	9 ☐ Unknown Part II. Other significant conditions contribution	ag to death but not reculf	ing in the ur	derhing cause give	on in Part I	23e Did tob	acco use con	tribute to 1	the cause of death?	
ŝ	uires that the de signed by the a Id be detached i	b	Renal insuf	fiziency	ing in the di	idenying oadse give	nrint r valçı.		s 2000	3 ☐ Pro		
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Records,	has ge 2 :	Completed	73/100	racer (ec	11001			autopsy	ed?	prior to co death?	mpletion of cause of	
a	ilcian: Th certificate rector, pag	e Co	25. Was case referred to medical				26 Place of Dec	1 ☐ Yes 2	Mo	1 🗌 Yes	2∐ No	
₹	ysicia is cert directe	To B	examiner? 1 ☐ Yes 2 € No Hospita	l: 1 ☐ Inpatient 2 ☐ El	R/Outpatien	t 3 DOA Othe	10	lome 5 Reside		her (Speci	fy)	
ō	g Phy erthi			Date of Injury 2 (Month, Day Year)	8b. Time of	28c. Injury Work	at (?	28d. Describe ho	w injury occu	rred		
0	ath. r: After te funer	atio	1' ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Bay 1 star)	11,017		Yes 2 □ No					
Division of Vital	for Attendated after death Director:	ertification;	3 Suicide 6 Could not be determined 286	. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Num , State)	ber or Rur	al Route Number,	
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	O		T. N. L		4 - /	- data 1	and director'	waa/-\ - : 4		ato to d	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner:									
	o the o the omple	Mec	29b. Signature and title of certifier			29c. License	number	29	d. Date sign			
•	1		Jan Sa	mus		Δ.	36601		011	15%	2004	
	12		30. Name and address of person who complete	ed cause of death (Item 2	23a) (Type,	Print)	4 7 6 7			,	·	
			DAND W. BRI	ed cause of death (Item 2	901	Maple +	tre lak	-ma Par	k W	0 2	09/2	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re A	Sporks	1					
	Regist	rar	JAN 16 2004	1 com	100	7 3						

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 12, 2004 1:24 PM^M Leslie Kathleen Anderson /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Aug. 26, 1 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 □ M 2X F 84 1919 Washington, DC Director 579-38-3443 Usuel Residence of Deceden with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location toa State "natural", or items 23a or 28a-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Prince George's Laure1 Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 14804 Belle Ami Drive by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or item principle in the marked other than "natural", or item in in yor other traumatic event, the Medical Examinations. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: Black 3 XWidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Joseph Watson Wyoming Lillian Brooks 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harry Anderson - Son 10904 Brookwood Ave., Upper Marlboro, MD 20772 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland National
Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/16/04 4 □ Donation 5 □ Other (Specify) Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ultimate Life 621 Florida Ave., NW Washington, DC enne 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Septic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Necrotizing Pancreatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and use as the burial-transit Pneumonia-Left Lower Lobe resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Cholecystitis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cardiac Arrhythmia 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Renal Insufficiency page 2 s 2 🗆 (No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐XNo Certification: To 28a. Date of tnjury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jan. 13th 2004 Udapi MD Pereturge D24174 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Rd. Suite #380 Laurel, MD 20707 Padmaja S. Udapi, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 15 2004 Registrar

KICHARD C. ARNOLD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2004 Richard C. Arnold IANUAR4 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Medicas CONTE SALISBUM Moomico PENINSULA REGIONAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑** M 2□ F 577-48-8218 68 7, 1935 Director Washington, DC Usual Residence of Decedent hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Experiment our rediffed at 1 Yes 2 No **Funeral Director** Maryland Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 21853 11861 Tom Nichols Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 21 No Specify: ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'sny injury of other traumatic event, the Meany injury of their traumatic event, the Means in Singe. Elementary/Secondary (0-12) College (1-4or 5+) Fireman Fire & Rescue 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George C. Arnold 2 Tamsen Shannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa J. Henry/Daughter 18503 Country Meadow Road, Boyds, Maryland 20841 20b. Place of Disposition (Name of complety, crematory or other place)
Parklawn Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State January 19, 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2004 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 Suneral Service Line 21. Signatur M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the attending physicien and the defendence of the street o Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9□ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 🗌 Yes 2.XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Tes 2 9 No the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 🗌 Yes 2 🗆 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Princess harles 31. Date filed (Month, Day, Year) 32. Registral's Signature State JAN 16 2004

Registrar

	AMENTO#7	· · · O~	SOMETNIE /	20 /04			Marylaı		-		Health and <i>Death</i>	_	- (004	02433
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	Physiciar /Medica]	Richard	Wood A	veril:							Januar		2004	10:11 AM
	Examine		Facility Neme <i>(II</i> 7208 Fai		-	et end numb	er)					Location of Deat		ounty of Death	
	Funeral Director	5.	Social Security No 384-32-2	umber	6. Sex 1 🖾 M		Age (In yrs			nder 1 Year oths Days			th y, Year)1		y place (State or Foreign intry) ew York
	D >	_	ual Residence of a. State	Decedent 10b. Count			100 0	ity Town	or Location						10d. Inside City Limits
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	vith the Marion or 28a-fs	10	e. Street and Num		Some Ly		рег	nesu		. Zip Code			10g. Citize	en of What Cou	intry?
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21215-0020	ed within 72 hours e ygiene. ier then "neturel", o it, the Modical Exer-		(Speci Elementary/Secor	ify only highe	nt's Educatio est grade con	n mpleted) College (1-4d	or 5+)		Decedent's 'Give kind c life. DO NO CUTIV		pation orduring most of wo	orking	Amer	of Business/Ir ican Op sociati	tometric
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lary	s 1 and 2 should f Health and Men tem 27 Is marke other traumatic	19	a. Informant's Na						•	•	t and Number or F				•
e, r	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once.	20	Lawrence a. Method of Disp	H. Av	erill,	, Jr./	Brothe	r 2	Guind Disposition	ola Pi	Lace, Hot	Springs Date	Vil:	lage, A	K 71909
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altir	nit. Page partment o ortant: If I Injury or	21	4 ☐ Donation . Signature of Fur				Cre	mato	rium,	e and Addr	ess of Facility Ro	15,2004 bert A.	Pump	hrev Fu	aryland neral Home/
ă —	Depari Depari Impori any Ir		May	1) t			0689		Beth B	esda- ethes	Chevy Cha da, Mary	ase, Inc Land 208	. 755 14 – 35	7 Wisco	nsin Avenue
	Dhuaisian	23	shook, or hear	e disease, o t failure. Lis	r complicatio t only one ca	ons that caus luse on each	ed the dea line.	th. Dono	ot enter the	mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner	dis re:	mediate Cause (F sease or condition sulting in death)	Final 1	a	Hher	DS: C	or as a co	7C		diovasc	ular c	tise	ase	
	ficate be executed ficate be executed by physician end street the burial-transit edical Examiner	Se	quentially list con	nditions.	b		Due to (or as a co	nsequence	of):					
68760,	eath certificate be executed attending physician end for use es the burial-transit clan/Medical Examir	ca Ca tha	equentially list con any, leading to imi use. Enter Under use (Disease or i at initiated events	mediate lying njury	c		Due to (c	or as a co	nsequence	of).					
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of Vital Records,	The law requires that the death centrate has been signed by the attending page 2 should be deteched for use Completed by Physician/N												an autopsy rmed?	av cc	ere autopsy findings ailable prior to impletion of cause death?
3												10	res 2	No 11	□Yes 2 No
Vita	certificate rector, pag	25.	Was case referre		Hospit	tal:				To		ath Check only o	ne)		
	ling Phys		1 Yes 2 □ N Manner of Death		28	1 ∐ Inpa Ba. Date of Ir		28b. Tir Inj		28c. Inju		dome 5 hesio 28d. Describe I			(y)
Division	To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:		2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be	Be. Place of building,	Injury - At h etc. <i>(Speci</i> i	ome, farn fy)	n, str eet, fa			28f. Location (S City or Tox		Number or Run	al Route Number,
	To the Hospital within 24 hours e To the Funeral C completely filled		Certifier (Check only	1 Gertifyit	ng Physician Examiner: (to To the ber	st of my kno	wledge,	death occur or investiga	red at the ti	Ts. dats and plan	and due to the urred at the time	date and n	d trianner as s	itated.
	To the H within 24 To the F complete		one)		8	and manner	stated.			29c. Licen	*			signed (Month,	
	75+1	230	Patr	icid	Ton	rsko	The	ry)	mot			(Janua	ary 14	,2004
	F	30.	Name and addre	ss of person	who comple	ted cause of	death/(Iter	n 23a) (T	ype, Print)	se Ri	51916 1., Roca	Eville,	MD.	2085	2
	State Registrar	31.	Date filed (Month	n, Day, Year,	2004	32. Flegis	strar's Signa	ature	i d	book.	3	,			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:33 P M Ilya Borisovich Azerskiy January 13, 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 1 XM 2 □ F Ukraine 212-49-8088 91 Director June 28, 1912 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County or 28e-f show item 27 is marked other then "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinating by notified at 1 ☐ Yes 2 🖾 No Directo Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1135 University Blvd. West, Apt. 207 20902 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. If Item 27 is marked other then "netural", or Ite eny injury or other traumatic event, the Medical Exammes. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 22 Married Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Military Personnel Armed Forces 12 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Boris Azerskiv Rosl Lumelskaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1135 University Blvd. West, Apt. 207, Silver Spring, MD Sarra Azerskaya/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 16, January 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 □ Donation 5 □ Other (Specify) 2004 Olney, Maryland Norbeck Memorial Park 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespirat 70 Y **Physician** /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine MOCK or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physicien ar s the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ģ in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 D lmung 1 Yes this certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No 1 🗌 Yes 2 EP/Outpatient 3 DOA Medical Certification; To 27. Manner of Death
1 Death
2 Accident 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) EHE 45 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 02435 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Margie Graham Bloom January 20, 2004 1519 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth Nov. 14, 1923 South Carolina If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 80 251**-**34-**7**537 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or Itams 23a or 28a-f shown in strings to the restition at Frederick Maryland Adamstown 1 Yes 2 No Director 10e. Street and Number 3200 Baker Circle, Apt. I 227 10g. Citizen of What Country? 10f. Zip Code 21710 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Ever 1 Never Married Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Graham Anna Belle Crosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Ray Bloom, husband P.O. Box 234, Adamstown, Maryland 21710 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Smithsburg Crematory Jan. 23, 2004 Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney and Bastord PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Cardiovascular Disease 2 Yrs. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes Vital To the Funeral Diractor: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 14 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D 13971 January 23, 2004 ante 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) M.D., 300 West Ninth Street, Frederick, MD 21701 Robert L. Kaufmann, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

State of Manyland / Department of Health and Mental Hydiana 0 0 1

			Ola	te or Maryland		tificate of			Reg. No.		02400
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Beatrice Lo	retta	B	owser		2. Date of Dea Month Januel	Day 15.2		3. Time of Death 6:45 PM
}	Examir		4a. Facility Name (If not institution, give street a	4 23			4b. City, Town, or Lo	4.6		of Death	
			Goodwill Mennon			If Under 1 Year	Grantsu If Under 24 Hrs.			rett	
	Funeral Director		Social Security Number 173 18 0857 Usual Residence of Decedent □ Sex □ M 25	7. Age (In yrs. la	Yrs.	Months Days		8. Date of Birt (Month, Day MAY 9	1919	9. Birthpla Countr PENNS	ace (State or Foreign Y) YLVANIA
	fand		10a. State 10b. County	10c. City	, Town or Lo	cation				100	d. Inside City Limits
	Mary First	ģ	PA FAYETTE	Ŋ	1ARKLE	YSBURG					1 Yes 2 □ No
	7 288	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of	What Countr	y?
	h wit	a D	137 MAIN STREET			1545	9		U.S.		
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 1 If Y	s Decedent Ever in U,S ned Forces? Yes 2 🖾 No es, Give ar or Dates:		Was Decedent of I f Yes, specify Cub I ☐ Yes 2☑ No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specifi	e - America ck, White, et	
ğ	2 hot		15. Decedent's Education		16a. Deced	lent's Usual Occu	pation		16b. Kind of B		
7	Pan 7	Completed	(Specify only highest grade comp Elementary/Secondary (0-12) Col	leted) lege (1-4or 5+)	life. i	kina of work done DO NOT use retire	during most of worki	ng	BEAUT	Y SHO	P
2	ad wi	5	12		BE	AUTICIAN				EMPLO?	YED
pu	be file d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Surnan	16)	
<u> </u>	Meni Meni Barke	၉	EWING S. GLOVER						WORKM		
Nar	l 2 sh is m raum		19a. Informant's Name/Relationship (Type, Prin				t and Number or Rura		-	•	lode)
e,	1 and Health Im 27 Ther t		DOUGLAS FRIEND / EXE			SHURCH ST sition (Name of	C., MARKLE	YSBURG,	PA 154 20c. Location -		m State
٥	it of H		1 X Kurial 2 ☐ Cremation 3 ☐ Remova	from State ce	metery, crer	natory or other pla					
Baltimore,	rt. Per rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee	ASH		DE CEMET . Name and Addre		/18/04	FRIEN	DSVIL	LE, MD
Ba	Depa Impo any ir		21. Signatury of Turieral Service Licensee			. Name and Addit	ess of Facility		60 W.		
			4/10 /1500	ما الله			TERAL HOME				MD 21532 Approximate
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	e on each line.	. Do not ent	er the mode or dyr	ing, such as cardiac c	n respiratory at	rest,	1 1	Interval Between Onset and Death
į	Physician /Medical		Immediate Cause (Final	atheros	10.0	4	1	. /.	18000	- 4	5
	Examiner		disease or condition resulting in death) a		as a consec		araiovas	Cultr	ases	e .	s years
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7	tificate be executed og physician and as the burial-transit	Examiner	Sequentially list conditions,	Due to (or	as a conseq	uence of):				1	
6	e exe ian a urial-l	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c					**		1	
68,760,	ate b hysic the b	edical	that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):					
×/ ₩		5	d								
B S	v requires that the death cer been signed by the attendir should be detached for use	Physician/								İ	
P.O. B	the a	ysic	Part II. Other significant conditions contributin	_	-		ven in Part I.				the cause of death?
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g Q	uires sign ld be	d by		, ,				24a. Was	an autopsy		e autopsy findings
õ	v req beer shou	lete	cerebrorosculor	disea	318			perfo	med?	com	lable prior to pletion of cause eath?
Be E	ne lav s has ige 2	Completed						1 🗆 Y	′es 2ĺ X ′No		Yes 2□ No
ā	n: Ti ificate or, pa		25. Was case referred to medical				26. Place of Death	200	,	'U	res 2 10
\(\bar{\sigma}\)	sicla s cert	o Be	examiner? 1 Yes 2 No Hospital	: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	t 3 DOA Ot	her:	- No.	0.5	er (Specify)	
ō	Attending Physiclan: or death. actor: After this certific by the funeral director,	Ë	27. Manner of Death 28a.		28b. Time of				ow injury occur		
<u>5</u>	nding ath. r: Afte	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Wollin, Day Tear)	Injury		Yes 2□No				
Division of Vital Records,	I or Atte after des Diracto d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (5 City or Tow	Street and Numb m, State)	er or Rural i	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: On an								
	Vithir To th	Me	29b. Signature and title of certifier		1. 5		se number		29d. Date signe		-
	. ,,,,) MALLER M.	·m-	M	DO	02575	9:	Januar	4 15.	2004
	12	,	30. Name and address of person who complete			Print)	02575 +7 Ac	A	1 3 -	-	
	10		Walter K. Nauman	in M.D.	PO	Box 24	+7 Ac	ciden	+ M	D 2/	520
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure						

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DHMH 16 Rev 6/95

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Darrell Barger JANUARY 19, 2004 Elmer 17:54 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Yee NOV 29, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** ^{er)}1933 1 XM 2 ☐ F Μ̈́D 70 Director 218-30-0728 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location s filed within 72 nous accession 14 Hygiene.
I other than "natural", or fisms 23a or 28a-f show sevent, the Medical Example must be notified at Allegany Cumberland MD 1 XYes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 437 Dewey Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cement Finisher Carl Beit Company Pages 1 and 2 should be filed without of Health and Mental Hygie tant: If item 27 is marked other toury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Floda Mae (Goldlizen) Barger Elmer E. Barger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
437 Dewey Terrace Cumberland MD 19a. Informant's Name/Relationship (Type, Print) MD 21502 Rebecca Barger wife permit. Pages 1 and 2 s Department of Health ar important: If item 27 is any injury or other trau once. 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1/23/2004 Cumberland Mt. Hermon Cemetery MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Nam Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licens. 108 Virginia Avenue: Cumberland, MD 21502 ramus 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ANOXIC ENCEPHALOPATHY 6 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and is the burial-transit certificate be executed Due to (or as a consequence of) 68760 Physician/Medical as the t IF FEMALE: Box for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CORONARY ARTERY DISEASE Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has ours after death. laral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner' Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funaral I

completely filled Hospital 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cert 29c. License number JANUARY 20, 2004 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POONAI, VIK, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JAN 3 0 2004 Coaste Registrar

ORIGINAL

		1 - For State Registrar	State of Maryla		artment <i>rtificate</i>			ind M	lental Hy	giene Reg. No	4 U U L	+ 024	3
Physic	ian	1. Decedent's Name (First, Middle, Las	t)		-				2. Date of De	eath Day	/ Yea	3. Time of	Death
/Medi			e V. Bores						Januar			0255	Α
Exami	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, To	own, or	Location of	Death		4c.	County of De	ath	
		SunBridge Care C		to at black to 1	Elkt		If I lades 0	M Hea			Cecil		
Funeral Director			7. Age (<i>in yrs</i> □M 2♥F 85	. last birthday) Yrs.		Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da AUG 8,	th a <i>y, Year)</i>	9. B	irthplace (State or Country)	
		Usual Residence of Decedent	65						AUG 8,	191	8 Pe	ennŝylva	nıa
filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or items 23a or 28e-f show ont. the Medical Ever it we must be notified at		10a. State 10b. County	10c. C	ity, Town or Lo	cation							10d. Inside Cit	ty Lim
Mar e-fst	ctor	Maryland Cecil	F	Elkton								1 ∑ Yes	2 🗆
th the	Director	10e. Street and Number			10f. Zip C	ode				10g. Citi	zen of What C	Country?	
be filed within 72 hours after death with the Marylan lat Hygiene. do other than "netural", or items 23a or 28e-f show event. the Medical Exacti sectroust be notified at	ai	l Price Drive			219	21				U	nited :	States	
r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Deceder	nt of His	panic Orig	in? (Spe	cify Yes or No Rican, etc.)			erican Indian,	
or it	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give	1	1 ☐ Yes 25		Specify:	i donto i	moun, etc.)		Specify:	ille, etc.	
urai.	Completed by	3 ♥ Widowed 4 □ Divorced	Year or Dates:								зреспу.	White	
n 72 "net	lete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual (kind of work DO NOT use	Occupations done di	tion uring most	of workir	ng	16b. Ki	nd of Busines	s/Industry	
within ene. than	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)										
e filed within al Hygiene. other than '		12 17. Father's Name (First, Middle, Last)		HO	memake		18 Mother	's Name	(First, Middle,		Her Own	<u>n Home</u>	
	To Be	Frank Waszkiewic	7						e Eshmo		Jumame)		
should be and Menta is marked sumatic ev	-	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (S	Street au			I Route Numbe		Town State	Zin Codo)	
and 2 ealth ar n 27 is		Florence V. Bor							Maryla			Zip Code)	
a =		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name	of		D	ate		cation - City o	r Town, State	
Pages nent of nnt: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,	Removal from State HC	cemetery crem DIY Sep	natory or othe UIChre	er place) J.		ry 23,	Phi	ladelph	nia,	
교원분 중		21. Signature of Funeral Service Licens		metery	. Name and	Addrass		004		Peni	nsylvar	nia	_
Depa Impo any i			1. 4	Hi	cks Ho	ome	for É	uner	cals, P	. A.			
	0. 10	23a. Part1. Enter the disease, or comp	ications that caused the deat	th. Do not ent	3 W. S	Stoc	kton	Stre	et, El	kton	, Mary	and 219	21
Dharatataa		shock, or heart failure. List only o	ne cause on each line.	10	1 0-	,g,	0_		roopiiatory ai	1031,		Onset and De	eath
Physician /Medical		disease or condition resulting in death)	a. Mulli	Infacc	T UD	me,	nua					Unkn	202
Examiner			Due to (or as a consec	quence or):	· las	Aca	idous	r				100/00	
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	war	.,	146111					unkno	w
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Alhens	sclosos	515							Tenkno	2 . 1-
Attending Physicien: The law requires that the death certificate be executed redeath. redeath. ar death. exters there this certificate has been signed by the attending physician and softer. Where this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a conseq		7.2							(070)	102
rate be executed hysician and the burial-transit	icai		d										
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res that the death certifica igned by the attending pl be detached for use as t	Physician/Med	Zob. Was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Feta		Ectopic preg	00004				2	3d. Date of de	livery	
ed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of d		Other (speci						Month	Day Ye	ear
at the	h y	9 Dunknown					-						
es th gned be de	by F	Part II. Other significant conditions con		ulting in the un	derlying caus	se given	in Part I.		23e. Did to	bacco us	e contribute to	the cause of dea	ath?
w require been sig should b	ted	Diabetes Med	litus						1 U Y	'es 2□]No 3 □ P	robably 4 🖭 din	iknov
lawr as be 2 sh	Completed								24a. Was		24b. Were at	utopsy findings av	vailab
The ate h page	МО								autop perfor 1 🗆 Yes		death?	completion of cau : 2□ No	use o
Physicien: The lav this certilicate has ral director, page 2	Bec	25. Was case referred to medical					26. Place o	f Death	(Check only or		10,763	20140	
ysic nis ce dire	2	examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient	3□ DOA	Other:		-	e 5 ☐ Resid		Other (Spe	cifv)	
ng Pt fter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury a Work?			8d. Describe h			,,	
endir sath. or: Al	atic	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,		М		s 2 No						
To the Hospitel or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, stre	et, factory, of	ffice		28	8f. Location (S City or Tow	treet and	Number or Ri	ural Route Numbe	9 <i>r</i> ,
To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in I	Cer	,		,, ,,					ony or ron	n, Olale)			
losbi t hou uner uner	cai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, death	occurred at t	he time,	date and	place, ar	nd due to the c	ause(s) a	ınd manner as	stated.	
the H in 24 the F the F	Medicai		and manner stated.	and and or my				occurred	at the time, c	ate and p	olace, and due	to the cause(s)	
To T	2	29b. Signature and title of certifier	C 11 5			icense r			2	9d. Date	signed (Mont		
t		> Jachder	SMD		20	02	3322	-			1.22	1,04,	
4		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)		n F	-01	+ no	2 2	1001		
		J.J. SACHDEN	MD 118 No	orth of	Durk	0	5 5	th	100 M	D Z	721		
Sta	te	31. Date filed (Month, Day, Year)	32. Registral s signa	iture	-		7						
Registr	ar	MAN 3	0 2004	10		. 10	4 4						

		- State Registrar MEND#10a, epe 1. Decedent's Name (First, Middle, La	ast)							2. Date of Dea		Year.	3. Time of Death
Physicia /Medic		Philip Ellic	ott Barr	inger						Januar		2004	4:00 P.
Examin		4a. Facility Name (If not institution, given Mariner Health o				1	Town, or hesd	Location of	of Death		1	ity of Death	
					last birthday)	If Under		If Under	24 Hrs.	8 Date of Birt	1		-
Funeral Director		167-16-4062	1₽M 2□F	87	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Oct • 2	, Year) 1916	Penr	place (State or Fore ntry) ISylvania
D		Usual Residence of Decedent		100 0	ty, Town or Lo								10d. Inside City Lim
show	5	10a. State 10b. County			shingt		. C.	•					1 ☐ Yes 2 ☐ !
the M	ecto	D.C. 10e. Street and Number	-			10f. Zip	Code				10g. Citizen o	of What Cou	ntry?
3a or		4609 38th Street	N.W.				2001	. 6			United	d Stat	es
death	Funeral Director	11. Marital Status	12. Was Deceden		I.S. 13.	Was Deced	dent of Hi	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 14. R	ace - Ameri	
or Ite		1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12 Yes 2	No WW	11	1 🗆 Yes		Specify:				oify: Whi	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28e-f show event, I're Medical Exame and count for coulded.	ed by	15. Decedent's E	Year or Dates	•	16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of	Business/Ir	ndustry
hin 72 In "ne Media	plet	(Specify only highest gi	rade completed)	r 5+)	16a. Dece (Give life.				t of worki	ng			
ed wit	Completed	12	College (1-4o		Civi	.1 Ser	vant						nment
be filtal Hy	Be	17. Father's Name (First, Middle, Las Daniel Moreau Bat								(First, Middle, Benne		ame)	
hould d Mer marke	ို	19a. Informant's Name/Relationship			19b. Mailie	na Address	(Street a			I Route Numbe		m. State. Zi	p Code)
od 2 s lith an 27 is r r traus		Thomas H. Barring								apolis,		1403	/
of Healitem		20a. Method of Disposition	70	20b.	Place of Dispo	sition (Nar	ne of therplace	91.77		ate	20c. Location		
Page nent c ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify)	e Get	Medica					268411			D.G.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other traumatic event, it a Medical Exama actional for critical angone.		21. Signature of Funeral Service Lice	msee 20	7	2	o fumi	d-Address	18754	ary s	Service lington	s, Inc	2003	R 7
402 0 d		23a, Part1. Enter the disease, or cor	nolications that caus	ed the dea									Approximate
		shock, or heart failure. List onfi Immediate Cause (Final	y one cause on each	Jine.				3,					Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Coron		Artery	Disea	ise						
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ificate g phys as the			0.				-						
The law requires that the death certifical to has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			∃Ectopic p	regnancy					Date of deliv	
e deat he att	sicie	in the past 12 months?	4□ Pregnant 9□ Unknown	at time of		Other (sp					'	Vionth	Day Year
hat the d by t letach	Phy	9 Unknown Part II. Other significant conditions	contributing to death	but not re	sulting in the u	nderlying o	ause dive	en in Part I		23e. Did t	obacco use co	ontribute to	the cause of death?
signe d be o		Tay iii	3.0							1 🗆 🕆	Yes 2∰No	3 ☐ Pro	bably 4 Unkno
w requ	Completed									24a. Was	an 24	b. Were aut	opsy findings availa
sician: The law certificate has b rector, page 2 s	ошо									autop perfo	osy ormed?	prior to co death? 1 \sum Yes	ompletion of cause of
	a	25. Was case referred to medical						26. Place	e of Death	Check only o			
> 20 0	To B	examiner? 1 ☐ Yes 2∑ No			ER/Outpatie			4 LA INI		me 5 Resid			ify)
ing P	on:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Ir (Month, L	njury Day Year)	28b. Time o	f M	28c. Injun Work	yat k? Yes 2□		28d. Describe I	how injury occ	urred	
Attending r death. Sector: After oy the fune	Certification:	2 Accident investigati 3 Suicide 6 Could not	be 390 Bloom of	Iniury - At h	nome, farm, st			185 2		28f. Location (Street and Nu	mber or Rui	al Route Number,
after Direct	ertif	4 ☐ Homicide determine	building,	etc. (Spec	ify)		y, oo			City or Tov			
To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying F	Physician: To the be aminer: On the basis	st of my kn	owledge, deat	h occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s) and	manner as	stated.
the Horin 24 the Fu	Medical	one)	and manner	stated.	ation and/or in				atin occurr				
	2	29b. Signature and title of certifier		2				e number	71-		29d. Date sig		
6(3)	1	h					NE		pl a	24	(((7/0	7
30		30. Name and address of person who											

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** January 11, 2004 Mildred Bassford 6:00 PM /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** Months 1 ☐ M 21X F Aug. 20, 1906 Director 579-10-4529 97 Maryland Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend tent of Health end Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a, Stete 10h County 10d. Inside City Limits th end Mental Hygiene. 7 is marked other than "naturs!", or liems 23s or 28s-1 shor traumatic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No **Funeral Directo** Gaithersburg Montgomery Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 301 Russell Avenue, # 435 20877 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11X Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4 Nurse Health Care 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bassford George Grace Forwood 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health e important: If item 27 is any injury or other tra Margaret Barott/ Great Niece 6113 Quebec Place, Berwyn Heights, MD. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/13/04 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Fecility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical a Aspiration Pneumonia 24 hours Examiner Due to (or as a consequence of) Examiner Dementia or Attending Physician: The law requires that the death certificeta be axecuted for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 Yes 2 No é cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2K No 1 ☐ Yes 2 ☐ No : After this certification at the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ₺ Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Tyes 2 No investigation death Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct complataly fillad in by 4 Homicide 29a. Certifier া 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. cal 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 58681 January 13, 2004 eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Alexander,

JAN 14 2004

31. Date filed (Month, Day, Year)

M.D.,

32. Registrer's Signature

9901 Medical Center Dr., Rockville, MD. 20851

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			1 = For State Registrar	State of Mary	land / Dep	artment of I	Health and	Mental Hygi	9	+ 0244
	Physici	ian	Decedent's Name (First, Middle, L.	,	Danata			2. Date of Death Month	Day Year	
8 . 4	/Medi			Donald Snead	Baxter				7, 2004	6:20A M
	Examir	ner	4a. Facility Name (If not institution, g				or Location of Deat	h	4c. County of De	
200	× 144	200	Montgomery Hospi 5. Social Security Number 6.		se yrs. last birthday	Rockvil		P. Date of Birth	Montgome	
78.00	Funeral Director		231-36-7391	1XM 2□F 71		Months Days		8. Date of Birth (Month, Day, Aug. 18,	1932 V:	irthplace (State or Foreigi Sountry) irginia
7	and Maria		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
4	rany.	ō	Maryland Montgo			aithersbu	ra			1 √2 Yes 2 □ No
į	289-	rect	10e. Street and Number	in a L y		10f. Zip Code		100	g. Citizen of What C	Country?
4	3a or	0	18736 Purple Ma	rtin Lane		2087	9		nited Sta	
0	is I am Z should be filed within 72 hours allel leath with the maryland if Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23e or 28e-f show other traumatic avent, the Medical Extrining Lavar be inclined at	by Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13.		Hispanic Origin? (S pan, Mexican, Puerl		14. Race - Am	
0	or Ite	Ē	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 XYes 2 ☐ No				o Rican, etc.)	Black, Wh	ite, etc.
2	in in in in in in in in in in in in in i	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: K	orea	1 ☐ Yes 2 🖾 No	Specify:		Specify: 1	White
Maryland 21215-0036	netu	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dece	dent's Usual Occup	pation	tking 16	6b. Kind of Busines	s/Industry
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7	and Mental Hygiene. Is marked other than aumatic avent, the Mental		47 5 4 4 4 4 4 4 4 4 4	3	Sal	es Manag			Glass	
מות ק	ave aver	Be	17. Father's Name (First, Middle, Las	,				ne (First, Middle, Ma	.,	
aryia	nark natic	P	Condon Austin B					Thomas Hov		
	h and 7 is n		19a. Informant's Name/Relationship		1			ral Route Number, (
a 3	Health Health Iem 27	1 8	Barbara Andrews I		Db. Place of Dispo		artin Lar		rsburg, Ma Oc. Location - City o	aryland 2087
פֿר פֿ	To H of		1 ☑ Burial 2 ☐ Cremation 3	Removal from State	cemetery, cre	matory or other pla	i Janu	ary 9.		
Baitimore,	Department of Health mportent: If item 27 any injury or other tr. 2006.		*4 □ Donation 5 □ Other (Spec			n Memorial	Park 20)04 P:	rince Geor	rge, Virgini
ממ	Department of the Importent: If ite any injury or of once.		21. Signature of Funeral Service Lice	-	0198 Rc 75	bert A. 57 Wiscon	Pumphrey sin Ave	Funeral H Bethesda	lome/ Chas MD 20814	esda-Chevy se, Inc.
P	hysician		23a. Part1. Enter the disease, or conshock, or heart failure. List ont immediate Cause (Final disease or condition	nplications that caused the cy one cause on each line. Rectal (ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death Months
	/Medical xaminer		resulting in death)	Due to (or as a cor						Honens
•	.xammer,	_	Sequentially list conditions,	b						
7	is is	lne	Sequentially list conditions, any, leading to simediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sequance of):					
The state of	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	sequence of):					
ה ה ה	sicien and buriat-transit	cal E		000 10 (01 23 2 001	isoquorico dij.					
os/ou,	physics the		•	d						
. Box 58/50,	attending ph	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of pre	egnancy					3083
DOX	atter	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 1 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Dale of de Month	Day Year
j 🖁	by the tached	ysi	1 ∐ Yes 2 □ No 9 □ Unknown	9□ Unknown						
1 4	ed b		Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
	n sign	d by						1 ☐ Yes	2 ∑ No 3 □ P	robably 4 Dunknown
5 3	should	Completed						24a. Was an	24h Were a	utopsy findings available
ב ק ק	ate has	mc						autopsy performe	d? prior to death?	completion of cause of
5 5		Ö	25. Was case referred to medical	1			Of Blace of Dee		Ño 1□Yes	2 No
OI VICAL RECORDS,	is cent direct	0 8	examiner? 1 ☐ Yes 2 💢 No	Hospital:	2 ER/Outpatier	at 3 DOA Oth		th (Check only one)	c ¥10+ (0	ocity) Hospice
<u> </u>		\vdash	27. Manner of Death	28a. Date of Injury	28b. Time o	28c. Injur	v at	28d. Describe how		nospice
Attending	ath. r: After e funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day Yea on	r) Injury	Wor M 1□	'k? Yes 2 ∐No			
Or Attending	after deatl Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determined		At home, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
Hospitei	within 24 hours after of To the Funerel Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying P	hysician: To the best of my miner: On the basis of exan	knowledge, deatl	n occurred at the tin	ne, date and place	and due to the caus	se(s) and manner a	s stated.
9	within 24 To the F complete	Medi	Une)	and manner stated.						
10	To no		29b. Signature and title of certifier			29c. Licens	e numper	29d	. Date signed (Mont	n, Day, Year)
6	+1		The up	ypul		D424	52	Ja	nuary 7,	2004
			30. Name and address of person who							
			Chitra Rajagopal 31. Date filed (Month, Day, Year)			Philip	Drive, #3	327, Olney	, Marylan	nd 20832
	Sta Registr		JAN 14 20	32. Registrar's S		Sparks	/			

DHMH 17 Rev 1/2001

Donald

-		-	For State Registrar	State of M	Marylan	id / Depa <i>Cei</i>	artment of H	lealth and i Death		giene 2 Reg. No.	004	02412
			Decedent's Name (First, Middle, Last,)					2. Date of De		V	3. Time of Death
	Physicia		(Charles I	Russel	1 Beav	ers		Januar	Day	2004	11:00 P ^M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number	er)		4b. City, Town, o	r Location of Death			inty of Death	
	Examin	er	Holy Cross Hospita				Silver	Spring		Мот	ntgome	rv
-	Funeval		5. Social Security Number 6. Se		Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th		place (State or Foreign ntry)
	Funeral Director		212-20-1969	ØM 2□F	76	Yrs.	Months Days	Hours Min.	June 5,			nny) ington, D.C.
		1	Usual Residence of Decedent						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ingcom, b.o.
١.	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
:	Mar Mar	ţ	Maryland Montgome	ery			Bethesda					1 ☐ Yes 2 No
-	death with the Maryland ms 23a or 28a-f show	<u>s</u>	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
	13a o	2	4702 Highland Aver	nue			2081	4		United	State	es
	deat ms ?	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		Race - Ameri Bleck, White	
0	after or Ite	3	1 ☑ Never Married 2 ☐ Married	1 XYes 2[] No		1 ☐ Yes 2 🖾 No	Specify:	o i ilouit, oto.,		cify:	, 610.
3-003e	within 72 hours after ene. then "natural", or Ite he Medical Examina	p	3 Widowed 4 Divorced	Year or Date	s: 1945–1	1947	243.10	opcony.		J.Pe	WI	nite
<u>ا</u>	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)		(Give	tent's Usual Occup	during most of wor	king	16b. Kind o	f Business/Ir	ndustry
7	ithin Ben .	du	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT use retired	,		77	4	
7	ygier ygier t, the	ပ္ပ	8			Furni	ture Ref		457	Hote		
and	be filed within 72 hours after death with the Marylan de Hygiene. I at Hygiene. I other then "natural", or Items 23a or 28a-f show other then "natural", or Items 23a or 28a-f show event, the Macifical Examilitation usit	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan			name)	
<u>z</u>	Men Men arke	ို	Rufus Choate Beav						Estelle			
Mar	and ls m		19a. Informant's Name/Relationship (T)				ng Address (Street					
2	and ealth n 27 ner tr	3	Carol A. Calderwoo	od/Niece	1001 5		Box 364,					
o C	4 i i s		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from Sta	te 205. P	emetery, crei	sition (Name of matory or other place	Janu	ary 16,	20c. Locatio	on - City or T	own, State
Ĕ	Pag nent ant: I		`4 □Donation 5 □ Other (Specify)		Con		al Cemeter	y 200)4	Washir		
Baltimore,	permit. Pages 1 and 2 should be filed with popertment of health and Mental Hygien Important: If item 27 is marked other in any injury or other treumatic event, Inspace.		21. Signature of Funeral Service Licens	500	M0019	8 Ro	Name and Addre bert A. 1 57 Wiscon	ss of Facility Pumphrey	Funeral	Home/	Bethes Chas	sda-Chevy se, Inc.
Ē			23a. Part1. Erter the disease, or comp	lications that caus	sed the deet						20014	Approximate Interval Between
4	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition		monia							Onset and Death 1 week
	/Medical		resulting in death)	Due to (or	as a conseq	uence of):						
	Examiner		Sequentially list conditions.	b. Seps								l week
	D #	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		as a conseq		42-04-04-04-00-04-0	** 1				
	ecute and trans	Examiner	that initiated events resulting in death) Last	U.			ive Lung	Disease				
Š.	e exercian a	ũ	1050iting in death) cast	`	as a conseq							1 1
8/60	cate be executed physician and the burial-transit	dical		d. Atri	al Fir	orillat	ion			.	-	l week
ã ×	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregna	ancy				23d.	Date of deliv	rerv
X R R	atter for u	clar	in the past 12 months?	1 ☐ Live birth]Ectopic pregnancy] Other <i>(specify)</i> _	1			Month	Day Year
j.	the d y the ched	isi	1 Yes 2 No 9 Unknown	9□ Unknowr	1							
J.	requires that the de peen signed by the a hould be detached f	4	Part II. Other significant conditions co	ntributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use c	contribute to	the cause of death?
ďs,	sign sign Id be	Completed by	Cardiomyopathy						10,	Yes 2□No	o 3 🗆 Pro	bably 4 ∰Unknown
Vital Record	w requir been si should	ete							24a. Was	an 24	th. Were aut	opsy findings available
ě	has b	E G							autor		prior to co death?	ompletion of cause of
<u></u>	i: The icate har, r, page	ပိ							1 Yes	2⊠ No	1 🗌 Yes	2 No
5	Physicien: The lav this certificate has al director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth	26. Place of Dea				
ō	Physicien: r this certific ral director,	7:	1 ☐ Yes 2 ☑ No	1 ∑lnpa 28a. Date of I		ER/Outpatier 28b. Time o	R 3L DOA	4 🗆 Nursing F	lome 5 Resident			('y)
	Jing After fune	io	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	Wor	k? Yes 2□No				
<u>s</u>	or Attending Ph after death. Director: After th in by the funeral	Ical	3 ☐ Suicide 6 ☐ Could not be		Injury - At h	ome farm sti	eet, factory, office		28f. Location (Street and Nu	ımber or Rur	al Route Number,
Division	after after Direct	Certification;	4 - Homicide determined	building,	etc. (Specif	(y)	001, 140101, 7, 011100		City or To			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Phy (Check only one)		s of examina							
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	~			29c. Licens	e number		29d. Date sig	gned (Month,	Day, Year)
			Dras	la	hi	0	D00	50209		Januar	y 11.	2004
I	5+1		30. Name and address of person who c	completed cause			Print)					
			Brian Shen, M.D.	1500 Fo	rest G	Glen Ro	ad, Silv	er Spring	g, Maryl	and 2	0910	
Н	Sta	ite ar	31. Date filed (Month, Day, Year) JAN 1 4 20		istrar's Signa	ature 4	Spark					

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** A^{M} January 8, 2004 8:40 Ruth A. Beck /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Bedford Court If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Hours 1 ☐ M 2 💢 F 100 Yrs. 25, 1903 Washington, 577-07-5256 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County rai', or Itams 23a or 28a-f ahow Examiner must be notified at 1 Yes 27 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itams 23a or: 3700 International Drive 20906 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed other than " Elementary/Secondary (0-12) College (1-4or 5+) Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sadie Virginia Shelby Stephen Robert Ashby 2 permit. Pages 1 and 2 should Depertment of Health and Milmportent: If item 27 is markeny injury or other traumati 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarkston, MI 4903 Lancaster Hill Drive, Apt. 292 48346 19a. Informant's Name/Relationship (Type, Print) Ruth Davis/Niece 4903 Lancaster Hill Drive, Apt. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 16 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Ft. Lincoln Cemetery | Brentwood, Maryland • 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signatura Service L M00803 Rockville, Inc. 300 Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction 6 days **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and resulting in death) Last Due to (or as a consequence of) Box 68760, by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 🖾 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 Yes 2 ₩ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 📆 Nursing Home 5 🗀 Residence 6 🗆 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ Inis filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident s after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43202 January 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlene Ozanne Blankfard, M.D. 3305 N. Leisure World Blvd., Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature State South IAN 14 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 1:28 A M **Physician** JANNARY GEORGE BOUSHELL J. 13 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 26, 1911 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral X** M 2 □ F 92 176-03-8621 New York Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County in then "natural", or Items 23s or 28e-f show the Medical Exercises must be notified at 1 ☐ Yes 2 ☐ No Prince George's Beltsville by Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 6835 Beaver Dam Road 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify: 3℃ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Printing Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 since.
Department of Health and Mental Hygiene importent: if Item 27 is marked other threin eny injury or other treumatic event, if a garde. Offset Pressman office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Harold Boushell Bertha Campbell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryson G. Boushell -son 6835 Beaver Dam Road Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 1/16/2004 Alexandria, Virginia ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COVONCEU Avtery Discuse Priysician unknown /Medical Due to (or as e consequence of): Examiner Hypertension Unkneu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and f-transit unknun The law requires that the death certificate be executed Mellitus Diubetes Due to (or as a consequence of): ing physician ar P.O. Box 68760. Physician/Medicai the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 🖺 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown VASCULOW discuse 7 mpho Saverma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2√ No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 155 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO - huisin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luck Rd Lanham 3118 Remsen Cood Steven 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 6 2004 Registrar

04-00236 RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 02415 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2004 **Physician** 0805 P.M January June D. Bray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year Nov. 14, 19) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F 78 New York 579-26-1303 Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f show 1 ☐ Yes 2 TNo Maryland Montgomery Bethesda Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20817 23a 10320 Westlake Drive, #408 United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite eny injury or other traumatic event. If a Medical Exartmen 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify ģ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Institutes Elementary/Secondary (0-12) College (1-4or 5+) of Health Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maurice Willson Beatrice Irene Lufkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14509 Church Street, Upper Marlboro, MD 20772 Bonita L. Bray/ Daughter 20b. Place of Disposition (Name of competery, crematory or other place)
Montgomery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

*4 ☐ Donation 5 ☐ Other (Specify) January Crematorium, Inc. 14, 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, 21. Signature of Funeral Service Licenses 23a. Part the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hope, in an failure. List only one cause on each line. Rockville, Maryland 20850-2805 **Physician** Mu ple disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physicien and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

12 As 2 No 24a. Was an autopsy performed 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1XYes 2 No 6 ☐ Other (Specify) Certification: To After th funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Ledestrian Struck 27. Manner of Death 1 Natural 5 Pending 9-04 1 Yes 2 No an 2 Accident investigation deliver after death npletely filled in by the 3 Suicide 6 Could not be determined 281. Location (Street and Number of Ryral Roule Number of Sity of Town) States The Company of the State of th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide street To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year, January 11, 2004 29c. License number 29b. Signature and title of pertifier O.C.M.E. NO Too 30. Name and address of person who completed cause of reach (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ONICA AtRICIA

State Registrar

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

Sporks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** January 8, 9:55 A.M. Joseph R. Brewer, Jr. 2004 /Medical 4b. City. Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number Birthplece (State or Foreign Country) Funeral Days Months Hours 1 M M 2 □ F Yrs. 73 Director June 2, 1930 Washington, D.C. 577-44-3148 Usuel Residence of Decedent Pagas 1 and 2 should be filed within 72 hours efter death with the Maryland mant of Heelib end Mental Hygiene.
ant: If item 27 is marked other than *natural; or items 23a or 28e-f show ury or other thatmatic event, me Medical Engineer must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 ☐ Yes 2 No Funeral Director Maryland | Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number United States 5011 Aspen Hill Road 20853 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 N Yes 2 No If Yes, Give Year or Detes: Korea 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Recruiter Recruiting Agency 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Joseph R. Brewer Ula Heard 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Karyn B. McAuliffe/ Daughter 21001 Cog Wheel Way Germantown, Maryland 20876 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 13, 2004 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licensee Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00198 23a. Part. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Due to (or es e consequence of) Physician/Medical Examiner bunal-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last as tha Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown tes Be Completed by page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 Yes 2 70 1 □ Yes 2 □ No. funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Volume 1 → Nursing Home 5 □ Residence 6 □ Other (Specify) edical Certification: To 1 Yes 2 No this 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1. Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Tes 2 No investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 571 30 Name and address of perso completed cause of death (Item 23e) (Type 31. Date filed (Month, Day, Year) JAN 12 32. Registrar's Signature 2004

Registrar

			For State Ragistrar	State of M	larylan		artmen rtificat					giene 2 Reg. No.	1001	02447
			1. Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physicia /Medic		Helen A. Brown								Januar	y 14,	2004	7:42P M
Ser.	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City,	Town, or	Location	of Death		4c. Co	ounty of Dee	eth
			177 Crossbow Lar						burg				ntgom	
	Funeral		Social Security Number 6. Security Number	x 7. A]M 2∭3 F		last birthday) Yrs.	Months Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Sept.	th iy, Year) O 1 OO	0	rthplace (State or Foreign ountry)
	Director		577-36-5311 Usual Residence of Decedent		73	113.					Sept.	9, 193	o wa	shington, DC
	and w		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Manyl 1 ehc	ō	Maryland Montgome	rv	Gai	therst	ourg							1 ☐ Yes 2 🙀 No
	286 100	rect	10e. Street and Number	- L J				Code				10g. Citize	n of What C	country?
	3 or	Funeral Director	177 Crossbow Lane				20	878				Unite	d Sta	tes
	deeth ms 2	nera	11. Marital Status	12. Was Deceden	Ever in U	.S. 13.	Was Dece	dent of Hi	ispanic Or	igin? (Spe	cify Yes or No Rican, etc.))- 14.	Race - Am Black, Wh	erican Indian,
9	or Ite	Ē	1 Never Married 2 Marned	Armed Forces 1 ☐ Yes 2 X If Yes, Give			1 ☐ Yes		Specify.		mouri, oto.,		pecify:	no, oto.
93	ral', o	l by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates									W	hite
5-0	72 h natu	ete	15. Decedent's Edu (Specify only highest grad	cation le completed)		16a. Dece (Give	dent's Usu kind of wo DO NOT u	ork done o	during mos	st of worki	ng		of Busines	•
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or liems 23a or 28e-f ehow than Madical Exerciner man be mulified at	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		nistr		,			Cent		ntelligence ency
2	Hygie ther	e Co	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle	, Maiden Su		
an	d be antai	To Be	Clarence E. Tansi	111					Kat	heri	ne E. R	lichar	dson	
Maryland	shound M	T	19a. Informant's Name/Relationship (T)			19b. Maili	ing Addres	s (Street a	and Numb	er or Rura	l Route Numb	er, City or T	own, State,	Zip Code)
M	nd 2 aith a 27 is		R. Bruce Brown/So	on		1523	West	Kers	sey L	ane,	Potoma	ıc, Ma	rylan	d 20854
ē,	tem Item		20a. Method of Disposition	2 14 Can		Place of Disponentery, cre	matory or	other plac	(e)	Janua	ry 19,	20c. Loca	tion - City o	r Town, State
E	Page In the Page		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		" Ga	te of Ceme	Heave tery	en	i	2004		Silve	er Spi	ing, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show among night or other treumatic event, the Medical Examiner must be notified at ance.		21. Signature of Cheral Service Lice	00		R^2	2. Name a OCKVÍ	id Addres	Inc.	ity Robi	ert A. West M	Pumph lontgo	rey F merv	uneral Home/ Avenue
<u> </u>	89 2 2 9		1. Shirt	ery.		1003 K	ockvi	lle,	Mary	Land	20830	1-2803		
ч			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caus ne cause on each	ed the deat line.	h. Do not en	ter the mo	de of dyin	g, such as	s cardiac c	r respiratory a	irrest,		Approximate Interval Between Onset and Death
A C	Physician		tmmediate Cause (Final disease or condition resulting in death)	a. <u>Acute</u>			Infa	rcti	on					1/2 Hour
	/Medical Examiner			Due to (or a			D:							10 Years
104		P.	Sequentially list conditions, if any, leading to immediate	b. Corona Due to (or a			Disea	se						TO TEATS
	uted j ansit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events											
Ć.	death certificate be executed e attending physician and of for use as the burial-transit	Exa	resulting in death) Last	Due to (or a	s a consec	uence of):								
760,	ysicia y bu	cal	(d										
99	ng ph as th	Physician/Med	IF FEMALE:											
Вох	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth	2 Feta	al death 3	□Ectopic p		,			23	 d. Date of d Month 	elivery Day Year
0.	e des the ar	sici	1 ☐ Yes 2 📉 No 9 ☐ Unknown	4□Pregnant 9□ Unknown		leath 5	Other (s	ресіту)						
Θ.	w requires that the de been signed by the s should be detached	Ph	Part II. Other significant conditions co	entributing to death	but not res	sutting in the i	underlying	cause giv	en in Part	l.	23e. Did	tobacco use	contribute	to the cause of death?
Records,	signe d be	Completed by	High Cholestero	_							1 🗆	Yes 2X	No 3 □ I	Probably 4 Unknown
Ö	require should	etec									24a. Was	san	24h Were a	autonsy findings available
3ec	has b	m	Hypertension								auto	ormed? 2 No	death?	autopsy findings available completion of cause of
al	n: The ficate h		25. Was case referred to medical						OF Place	o of Doct	1 Yes		1 ⊔ Y€	es 2 No
Vital	Physicien: The law this certificate has be ral director, page 2 s	o Be	evaminer?	Hospital: 1 ☐ Inpa	tient 2	ER/Outpatie	ent 3□ □	Oth Oth	05		me 5X Res		Other (Sc	necify)
of	d = 6	n: To	27. Manner of Death	28a. Date of Ir	niury	28b. Time		28c. Injur			28d. Describe			
ion	Attending F r death. ector: After by the funera	atio	1 Natural 5 Pending 2 Accident investigation		day Year)	Injury	М		Yes 2]No				
Division	Attendii er death. ector: A by the fu	iffica	3 Suicide 6 Could not be determined	200. Flace 01	Injury · At h	ome, farm, s	treet, facto	ry, office				(Street and	Number or i	Rural Route Number,
D	tel or rs afte al Dir	Certification:												
	lospi t hour uner	edicai	29a. Certifier (Check only 2 Medical Exam	iner: On the basis	of examin	owledge, dea ation and/or i	th occurre	d at the tin	ne, date a pinion, de	ind place, eath occurr	and due to the ed at the time	cause(s) a , date and p	nd manner : lace, and di	as stated. ue to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medi	one)	and manner	stated.		/		e number					nth, Dey, Year)
	To To	-	29b. Signature and title of certifier	///	1		M							
	10		- jou	VI		-02:1/~	77	D11	921			Janua	ry 15	, 2004
			30. Name and address of person who of John A. Galotto,					Road	#1Δ	. Ret	hesda,	Marv1	and	20814-2053
	St	ate	31. Date filed (Month, Day, Year)	32. Regi	strar's Sign	-		out,		, 500		<u>-</u>		
			18N 1 C 20	TIA DA	all the	1	LHO	were.						

			1 = For State Registrar		State of M	aryland	l / Depa <i>Cei</i>	artment of F rtificate of i	lealth ar <i>Death</i>	nd Mental	Hygie Reg.	stream Tab	04	02418
	Physici	an	1. Decedent's Name (Fire	st, Middle, Last)		-			2. Date Mont	of Death	Day	Year	3. Time of Death
	Physici /Medio		Miriam Mild							1-12	- 04			3:40 A. M
	Examir	ier	4a. Facility Name (If not i	-		•		4b. City, Town, or		Death		4c. County		
			Holy Cross 5. Social Security Number			ge (In yrs. la:	et hirthday)	Silver S		Hrs. 8. Date		Montg		
	Funeral Director		088-14-890)2	_M 2⊠F		31 Yrs.	Months Days		Min. (Mon.	th, Day, Ye -1922		P. Birthp Court	elace (State or Foreign etry)
	land		Usual Residence of Dece 10a. State 10b	. County		10c. City,	Town or Lo	cation					1	Od. Inside City Limits
	Many -1 sh	ţ	MD M	ontgome	ry	Silv	er Sp	ring						1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number					10f. Zip Code			10g.	Citizen of V	Vhat Coun	itry?
	th with	a D	10701 Kini	loch Rd	•			2	0903			U.S.A	. •	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or terms 23a or 28a-f show event. I're Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 □ [_	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	,		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	ispanic Origir In, Mexican, f Specify:	n? (Specify Yes Puerto Rican, et	or No-		e - Americ k, White, Whi	etc.
5	72 h natu	etec	15. [(Specify on	Decedent's Edu	ication le co <i>mpleted)</i>		16a. Deced (Give	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most o	f working	16t	. Kind of Bu	siness/Ind	Justry
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2	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, I'm M		12 17. Father's Name (First,	Middle (ast)			Homen	laker	18 Mother's	s Name (First, M		wn hor		
an	d be antal	o Be	George Fa							ldred F			b)	
<u></u>	should be and Mental marked o umatic eve	ဥ	19a. Informant's Name/F		rpe, Print)		19b. Mailin	g Address (Street a					State Zin	Code)
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re,	s 1 and 2 of Health item 27 I		20a. Method of Disposition	on		20b. Pla	ce of Dispo	sition (Name of natory or other place	al J	Date		Location -		wn, State
Ë	Pages nent of ant: If it		1 ☑ Burial 2 ☐ Cre `4 ☐ Donation 5 ☐					leaven		-16-04	Si	.lver	Sprin	ng, MD
Baltimore,	permit. Pages 1 and Department of Health Important: If item 21 any injury or other to once.		21. Signature of Funeral	Service Licens	Duly	ine		. Name and Addres		Hines-R	inald	li F.	н.	
			23a. Rart1. Enter the dis shock, or heart faile	sease, or compl	ications that caused	d the death.							Sprin	ng, MD 2090 Approximate
	Physician		Immediate Cause (Final							-				Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)		Due to (or as									
	Examiner				Respira	1100		re						
	الجيد	Je.	Sequentially list condition if any, leading to immedi- cause. Enter Underlying Cause (Disease or injury	ns, ate	Due to (or as			10						
	tificate be executed g physician and as the burial-transit	Examiner	triat initiated events		Lung Ca									
68760,	e execian a		resulting in death) Last		Due to (or as	a conseque	nce of):							
876	cate b ohysic the b	edlcal			d									
Box 6	ath cer ttendir or use	Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 month	main ,	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)				23d. Date Mor	e of delive	ry Day Year
o.	that the de led by the a detached t	Jysk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9☐ Unknown		0_	Cities (Speciny)						
о <u>.</u>	requires that the een signed by th hould be detache	by Pi	Part II. Other significant	conditions cor	ntributing to death b	ut not resulti	ing in the un	derlying cause give	n in Part I.	23e.	Did tobacc	o use contr	ibute to the	e cause of death?
ğ	w requires been sign should be	ed b									1 🗌 Yes	2 🗆 No	3⊠ Proba	ably 4 Unknown
လ လ	> 10 0	ompleted									Was an	24b. V	Vere autop	sy findings available
Ä	0 5 0	mo									autopsy performed ′es 2∑	? d	rior to com eath? □Yes :	apletion of cause of
ita	ysician: The is certificate director, pag	BeC	25. Was case referred to examiner?	medical					26. Place of	Death (Check of				
<u>></u>	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No	F	fospital: 1 🖾 Inpatie	ent 2 🗆 EF	NOutpatient	3□ DOA Othe	or: 4 🗆 Nursii	ng Home 5□	Residence	6 □Othe	r (Specify))
n o	ng Pl		27. Manner of Death 1 XNatural 5 □	Pending	28a. Date of Inju (Month, Day	ry y Year) 21	Bb. Time of Injury	28c. Injury Work			ribe how in	jury occurre	ed	
sio	Attending r death. ector: After by the fune	catl	2 Accident	investigation Could not be					/es 2 □ No	-				
Division of Vital Records,	l or At after o Direc	Certification:	4 Homicide	determined	28e. Place of Injuding, etc	ury - At hom c. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Locat City o	ion <i>(Str</i> eet r Town, St	and Numbe ate)	or Or Rurai	Route Number,
	Hospital		29a. Certifier 1 🖾 (Certifying Phys	sician: To the best	of my knowle	adne death	accurred at the tim	o data and a	lace and due to	the sever	(a) and made		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 1 h	Wedical Exami	ner: On the basis of and manner sta	examination	n and/or inv	estigation, in my op	inion, death	occurred at the t	ime, date	and place, a	nd due to	the cause(s)
	To the within 7 To the comple	Σ	29b. Signature and title o	f certifier	1 .			29c. License	number		29d. I	Date signed	(Month. D	lay, Year)
	./		· Mu	Stee	Maria	le 1	W	DOC	25601	55		1/12	-104	<i>F</i>
	1>		30. Name and address of	person who co	impleted cause of d	eath (Item 2	3a) (Type, f	Print) KRIS	SIE D.	21 M	K, M.D.	209	10	
	Sta		31. Date filed (Month, Da		32. Registra	ar's Signatur	0 4	has it	1					
	Registr	ar	JAN	1 6 200	4 Sans	a man	14	sporks						

Miriam Brown

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MYRON CONNER BRUCE Month TAN 08y 2004 0454 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Yea Dec. 10, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 XM 2 ☐ F 253-40-9836 75 Director 1928 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow ordant: If item 27 is marked other than "natural; or items 23s or 28s-1 show injury or other traumatic event, it a Mudical Examinar must be notified at a. s. 1 X Yes 2 □ No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Denham Road 20851 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1949— If Yes, Give 1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1969 1 ☐ Yes 2 🂢 No Specify: Completed by Specify. White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Chin E 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Chief Nava1 Electricians Mate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Cletus Bruce Sr. Etta Mae Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley C. Bruce/ Wife 608 Denham Road, Rockville, MD 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State January important: * 4 □ Donation 5 □ Other (Specify) Parklawn Cemetery Rockville, MD 2004 22. Name and Address of Facility DeVol Funeral Home, Park Drive, Gaithersburg, MD 20877 permit. 21. Signature of Funeral Service Li 10 East Deer ICACI ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation or Attending 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Curice K po 101233170 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER JANINE R. DANKO MC USNR BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) JAN 13 32. Registrar's Signature 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:17 am Cyril Anthony Buehrle 2004 January 10, /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yeer) **Funeral** Birthplece (State or Foreign Country) 1⊠M 2□F Days Yrs. Director 216-44-7593 89 New York Feb. 9, 1914 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow r than "netural", or items 23e or 28e-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17512 Princess Anne Drive 20832 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1347es 2 □ No 11 Yes, Give Year or Dates: 1943–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than enry injury occurrent traumatic event, the MODGE. Accountant 4 Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Charles Buehrle Kathryn Hannes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Buehrle/ Wife 17512 Frincess Anne Drive, Olney, MD
Disposition (Name of Date Date Date 20c. Location - City 20832 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State January 14 *4 ☐ Donation 5 ☐ Other (Specify) 2004 Silver Spring, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facilit Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ore lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA WEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à MYOCARDIAL INFARCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed PROSTATE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificate has b lirector, page 2 st 24a. Was an autopsy performed Division of Vital 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 12 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di completely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number 29d. Date signed (Month, Dey, Year) ames michael Archos No D29730 JANUARY 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50/75 210 MARYLAND JAMES MICHAGE ANCHORS NO 16220 FREDERICK RS GAITHERSBURG. 31. Date filed (Month, Day, Year) JAN 12 2004 32. Pegistrar's Signature State sacks

Registrar

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	Examir		4a. Fecility Name (If not institution		umber)				Location of	of Death			county of Dee		
			8557 Horseshoe		7 4 //-	to an tright do		COMAC er 1 Year	If Under	24 Hrs			ntgome		
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	nyland how		Usuel Residence of Decedent 10a. State 10b. County		10c.	City, Town or	Location							10d. Inside	City Limits
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yland	fental rked ric ev	To Be	Thomas Lewis Be	a11					M+1	dred	Scott		,		
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Σ,	and 2 ealth m 27		William H. Bur	k Son					Dr.		anicsvi	lle,	VA 2:	3116	
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N I G	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0.5		of Death (Check only one)			
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=	Attending Physician: r death. ector: After this certifics by the funeral director, p	tion	1 ♣ Natural 5 Pendin 2 Accident investig	g (Mor	ith, Day Year) Injury	м	28c. Injury Work 1 □ Y	ai ? ′es 2∐N		d. Describe ho	w injury c	occurred		
2	I or Attendi after death. Director: A I in by the fu	ifica	3 Suicide 6 Could r	not be 28e. Plac	e of Injury - A	t home, farm, s	treet, facto				f. Location (Str	eet and A	Number or Ru	ral Route Nur	nber,
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1	,		30. Name and address of person Saulius Naujoka	who completed cau aitis, M.	se of death (I	tem 23a) (Type 3301 Ne	, Print) w Mex	cico A	Ave.,	NW,	#349, W	ashi	ngton,	DC	
194 .b	Sta Registr		31. Date filed (Month, Day, Year) JAN 12	2004	egistrar's Sig	gnature	Sp	aks	/						

State of Maryland / Department of Health and Mental Hygiene?

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JAN 16

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Eleanor Frances Curry 01/17/2004 1635 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 10/04/1924 1 ☐ M 2 🔀 F 218-16-1878 79 Yrs Director Marýland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "naturel", or Items 23e or 28a-f shov The Medical Examiner must be notified at 1 Yes 2 □ No Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12921 Carmel Avenue 21842 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after /6 35-21215-0036 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Tes 2XXIII White þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Social Security Office **US** Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward McCoy Estelle Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Curry (husband) 12921 Carmel Avenue Ocean City, MD 21842 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 200 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ä Cape Henlopen Crem, 01/18/2004 Frankford, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part1. Enter the disease, or complications that clused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neuminia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Cther (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 □No 3 ☐ Probably 4 ☐Unknown Completed 245. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy 1 ☐ Yes 2☐No After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) /2 No 1 Tes 1 Inpatient 3 DOA Medical Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ___atural 1 ☐ Yes 2 ☐ No death. nours after death neral Director: / filled in by the f 2 🗆 Accident 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53612 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 modre Daver 31. Date filed (Month, Day, Year) JAN 2 32. Registrar's Signature State 0 2004 Registrar

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		For State Registrar	State of	Maryland		rtment <i>tificate</i>			ind M		giene	104	92	,51
		1. Decedent's Name (First, Middle,	Last)		17					2. Date of Dea	ath Day	Year	3. Time o	of Death
Physic /Med		Celia M.	Caraway							Januar			7:57	РМ
Exami		4a. Facility Name (If not institution, g	give street and numb	oer)		4b. City, T	own, or	Location o	Death			ity of Death		
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Funeral Director		,	. Sex 7. 1 □ M 2 🗓 F	. Age (In yrs. Ia 92	st birthday) Yrs.		Days	Hours	Min.	8. Date of Birt (Month, De Jan. 1	n y, <i>Yeer)</i> 3 1912	Cou	plece <i>(State</i> intry) Kansas	
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72 hours after netural, or ite	dby	3 N Widowed 4 □ Divorced	Year or Date	es:		I□Yes 2	M NO	Specify:			Spec	city:	White	
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ylall ould be ! Mental warked	0 8	William LaFerne	У					Edith	ı Sk	illion				
2 short and he is mais sums		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Numbe	r or Rurai	Route Numbe	er, City or Tow	n, State, Zi	p Code)	
and and m 27		_Diane C. Kestel	/Daughter	ant Die	1150	9 Dal	yn T	errac	e, P	otomac				
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Deficiency of the properties o	<u>'</u>	* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Li		Nat						6/04			ı, Va.	
Dall permit. Departr Imports any inje		21. Signature of Funeral Service Cit	2	7	22					UNERAL				
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Physician		shock, or heart failure. List or Immediate Cause (Final	nly one cause on eac		/	500	1	1,		1 0			Interval Be	
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after i Dire	Certification:	4 Homicide	building	, etc. (Specify)		,,				City or Tox	m, State)			
To the Hospital or Attanding Phyminin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physician: To the base and manner	is of examination	rledge, death on and/or inv	occurred a restigation,	it the tim	e, date and pinion, deat	d place, a	nd due to the	cause(s) and r	manner as s	stated. o the cause((s)
To the within To the	₹ Z	29b. Signalure and title of certifier			1			number			29d. Date sign			
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Ψ		30. Name and address of person w	ho completed cause	of death (Item		Print)	201	1 RC	1558	ELL A BURG	UENU ULD	208	77.	
S Regis	tate trar	31. Date liled (Month, Day, Year) JAN 15		gistrar's Signatu	ure &	Spo	reks	1						

State of Maryland / Department of Health and Mental Hygiene 1- State Registra MEND#10f, 14, 18, 19boer INF1/22/04BMcCertificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** Yeer 6:06 PM January 8, 2004 Robert L. Carelock /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14421 Jaystone Dr. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs 55 Director 018-36-1613 NC 11-11-48 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show rthan "natural", or Items 23a or 28a-f shov the Medical Evarriner mat be retified at 1 ☐ Yes 2 ☑ No Director Montgomery Silver Spring 10f. Zip Code 20905 10g. Citizen of What Country? 10e. Street and Number 20906 14421 Jaystone Dr. USA death v Funeral 14. Race - American Indian, Black, White, etc B 1 a C K 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after Il Hygiene other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No φ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Potomac Electri Power 18. Mother's Name (First, Middle, Maiden Sumame)
Trayham 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic svent size. Be Joe Carelock Margaret Trayhnam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 19a. Informant's Name/Relationship (Type, Print) Dr. Sally Flowers - Personal Rep. 14421 Jaystone Dr. Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □ Removal from State * 4 □ Dønation 5 □ Other (Specify) Gate of Heaven 1-15-04 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi F. H. 11800 New Hampshire Ave. Silver Spring, MD 20904 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral vascular accident Physician /Medical Due to (or as a consequence of): Examiner Valvular Heart Disease w/cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Il-transit The law requires that the death certificate be executed Pleural effusion Due to (or as a consequence of): physician a s the burial-t Division of Vital Records, P.O. Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sudden death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? Cardiopulmonary arrest 24a. Was an has autopsy performed? Yes 22 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.
To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ≥ No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ٩ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DC 20182 iD JANUARY 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 CONNECTICUT AVE, KENSINGTON MARYLAND 20895 DR WESLEY B MASON 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Dacks JAN 1 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene State RegistrarAMEND #18 perINF 1/20/04, BAWM Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10, 2004 6:05 Frances Kronberg Carter January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner National Lutheran Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 84 Yrs. June 9, Nebraska Director 505-30-8299 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show r then "netural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 United States 9701 Veirs Drive Funeral Race - American Indian Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) permil. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic swent once. 17. Father's Name (First, Middle, Last) Be Carrie Carlson Altenus Kronberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen C. Faulkner/Daughter 1103 Wintrol Court, Herndon, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 17, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park Olney, Maryland 2004 Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Exfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Pnysician Zweeks /Medical Due fo (or as a consequence of): Examiner UROSEPSI Sequentially list conditions, if any, leading to immediate a se. Enter Under in Cause (Disease or injury Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical attending for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. P 9☐ Unknown 9 Unknown been signed to should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 🗆 No 2000 1 Yes 26. Place of Death (Check only one, Be 25. Was case referred to medical examiner? Other 4 Surring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this Alter the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the ! 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) mo D500612 enung 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19500 Amaranth Drive SAMUEL MALLOR Germantown, Maryland 20874 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 12 2004 Registrar

		For State Registrar	State of Maryla		artment of H			ene2001	02457
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death	Funeral Director	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No-	14. Race - An Black, Wh	
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12		Jell V	selverchio 1	לוא	1)4	4541		01107	107
		30. Name and address of person who James A. Del Vec	chio, M. D.	(Item 23a) (Type 1500 For	Print)	Rd., Sil	lver Spri	ng, MD 209	910
	State istrar	31. Date filed (Month, Day, Year)	32. Pegistrar's S	Signature 💪	Spark.				

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Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, o		eath		ounty of Death	
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othe		20a. Method of Disposition	20b.	Place of Diso	osition (Name of	1	Date nuary	20c. Loc	ation - City or T	own, State
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inju		21. Signature of Funeral Service License	6	1 2	2 Name and Addr	see of Eacility R	ohert A	Pumpl	roy Fu	neral Homo
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ithin 24 hours after death. o the Funeral Director; Alt ympletely filled in by the fun	Medical Certific	(Check only 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or i		se number			signed (Month	
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within 24 hours after death. To the Funeral Director: Alter completely filled in by the funer		(Check only 2 Medical Examination) 29b. Signature and title of certifier 2	ner: On the basis of examin and manner stated.	ation and/or in	29c. Licen	se number		29d. Date		. Day, Year)
		(Check only 2 Medical Examin	ner: On the basis of examinand manner stated.	ation and/or in	29c. Licen D56653	se number		29d. Date	signed (Month	. Day, Year) , 200 4

Regis DHMH 17 Rev 1/2001

10+1

Baitimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 8:20 PM 2004 Clayton Joseph Clawson January 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Director July 4, 1916 030-05-2032 87 Indiana Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23e or 28a-f ehow idical Examiner must be notified at 1X Yes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Russell Avenue #402 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 0.0 1 Never Married 2 Married 1944-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ College Professor 7 le markad othe treumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Iam 27 is marked oth any injury or other treumatic event ance. 18. Mother's Name (First, Middle, Maiden Sumame) Be Clayton Clawson Mary L. Bingham ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lance Clawson / Son 7809 Tomlinson Avenue Cabin John, MD 20818 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Jan. 13, Metropolitan Crematory 2004 Alexandria, Virginia 21. Signature of Juneral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Dementia 10 E. Deer Park Dr. Gaithersburg, MD 20877 Approximate Interval Between Onset and Death **Physician** Years /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit c Cerebrovascular Accident Years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as the ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 No 1 Yes 2 No 1 Tyes After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ XDOther (Specify) $_{1}$ Hospice Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation Injury death 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel (To the Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signatur and title 29c. License number 29d. Date signed (Month, Day, Year) D35635 January 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Joseph Kaplan, M.D. Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souks IAN 14 2004 Registrar

			1 - For Stata Registrar	State	of Mary	land / Dep <i>Ce</i>	artmen <i>rtificat</i>			and N	lental Hy	/giene			02460
			1. Decedent's Name (First, Middle	e, Last)							2. Date of De	eath			3. Time of Death
	Physici /Medi		STANLEY	S.		CLAY	MAN				JANUAR	Da Y 5,		ar	8:14 PM
	Examir		4a. Fecility Name (If not institution	, give street and nu	ımber)		1		Location of	of Death			. County of [
-			MANOR CARE				POTO						MONTGO		
	Funeral		5. Social Security Number	6. Sex 1 → M 2 ☐ F	7. Age (In	yrs. last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bit (Month, Da Dec 31	rth ay, Year)	9.	Birthplai Country	ce (State or Foreign
94	Director		215-38-5958 Usuel Residence of Decedent	Λ	00						Dec 31	, 19	I/ Wa	shir	igton, DC
	yland		10a. State 10b. County		100	City, Town or Lo	ocation							100	d. Inside City Limits
	Mar e-f si	tor	MD Montge	omery		Chevy Ch	ase								1 ☐ Yes 2 ☐ No
	or 28	ire	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of Wha	t Country	y?
	ath w	Tail	5600 Wisconsin	Avenue,	#306		2	0815				Uni	ted St	ates	5
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Iteme 23s or 28e-f show event. the Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Dec	orces?	in U.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)	o-	14. Race - /	American Vhite, etc	
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ş	2 hou	ed	15. Deceden			16a. Dece	dent's Usua	ol Occupa	ution			16h K	ind of Busine		nite
212	nin 77	Completed	(Specify only highest Elementary/Secondary (0-12)			(Give	kind of wor DO NOT us	rk done d se retired,	luring most	t of work	ing	100.1	and or busin	333/11 /4 (1)	stry
7	filed wit Hygiene other the	EOC	Comonary Good Gary (G-12)	5+	1-401 34)	Dei	ntist					De	entist	ry	
g	be file ital Hy d oth	Be (17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle				
<u>X</u>	should be filed ind Mental Hygi is marked other umatic event.	2	Harry	Clayman						ecca			Ede1s		
Maryland 21215-0036	a a a		19a. Informant's Name/Relations	nip (Type, Print)							al Route Numb				
e o	of Health Item 27 i		Jeanne Clayman	wife		5600	Wisco	onsi	n Ave		306 Che	_			
Baltimore,	Se = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	-Ştate	b. Place of Dispo cemetery, crei	natory or o	ne of ther place	e)	Į.	Date	20c. Lo	ocation - City	or Town	n, State
			'4 □Donation 5 □ Other (S		/ 13	Judean Me						01ne	ey, Ma	ryla	ınd
a D	permit. Departitimport		21. Signature of Furieral Service	Joensee /	1	D_{s}^{22}	2. Name an 3. NZ 3. NS	dAddres Sky−(s of Facility GO1db	y erg	Memoria	al Ch	napels	, In	ıc.
			23a Part 1 Frier the disease of	complications that	g 222		170 Ro	ockv	ille	Pike	Rocky	71116	e, MD	_208	52
	4 m		23a. Part 1 Enter the disease of shock, or heart failure. List Immediate Cause (Final	only one cause on e	each line.	Journ Do Hot one	or the modi	o or dynig	, such as t	cardiac	n respiratory a	11621,		In	pproximate Iterval Between Inset and Death
	Physician /Medical		disease or condition resulting in death)	-	UMONIA										
	Examiner			ma .		sequence of): R'S DISEA	ASE								
W.	Miles .	Je.	Sequentially list conditions, if any, leading to immediate	b		sequence of):	IOL							_	
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
oʻ	en ar	EX	resulting in death) Last		(or as a con	sequence of):								+	
2/00	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	dical		d											
õ	ertific ling p e as l	Mec	IF FEMALE:						- Toules		_				
X Q Q	death co	hysician/Me	23b. Was decedent pregnant in the past 12 months?		oirth 2 🗆 F	etal death 3	Ectopic pre					1	23d. Date of Month	delivery Da	tv Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregr 9∐ Unkn	nant at time own	of death 5 □	Other (spe	ecify)					WOUTH	00	iy rear
7.	The law requires that the ate has been signed by th page 2 should be detache	Δ.	Part II. Other significant condition	ns contributing to d	eath but not	resulting in the ur	aderlying ca	use awe	n in Part I		23a Did to	obacco u	isa apatabut	a to the e	cause of death?
g.	sign d be	d by	•			rooming in the or	raerry irrig ca	iuse give	mar anti,					_	y 4 Unknown
000	w req	ete									1	/es 2[
Č L	he lay e has ige 2	ompieted									24a. Was autop		24b. Were prior death	to compl	r findings available letion of cause of
	ificate or, pa	ပိ	25. Was case referred to medical								1 Tes	2 🔀 No		es 2	□ No
>	s cert	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	inpatient a	2 🗌 ER/Outpatien	t 3 🗆 DO	Other			(Check only o				
5	g Phy er thi	n:T	27. Manner of Death	28a. Date	of Injury	28b. Time of		c. Injury Work			ne 5 Resid			pecify)	
VISION	ath. r: Aft	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investig		th, Day Year	r) Injury	М		? es 2⊡N	lo					
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - A	t home, farm, stre	et, factory,	office		2	28f. Location (S	Street and	d Number or	Rural Ro	oute Number,
5	itel or rs aft el Di led in			Julio	11g, 010. (Op					4	City or Tow	m, State,	,		
	Hospi 4 hou runer ely fill	edicai	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the	best of my	knowledge, death	occurred a	it the time	o, date and	place, a	and due to the o	cause(s)	and manner	as state	d.
	To the Hospitel or Attanding Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Med		and man	ner stated.										
	¥ ¥ 6 8	-	29b. Signature and title of certifier	91 1		14.0	29c.	License					e signed (Mo		
	V		20 Alema and addition	V/V	N.S.	/ 7()		D29	353			Janu	ary 7	, 20	U4
			30. Name and address of person v					7m	#005	5 0	horr- O	200	MD C	0015	
	Sta	te	George W. Grave 31. Date filed (Month, Day, Year)	32.	egistrar's Si	gnature /) (.	hevy Ch	ase,	MD 20	78T2	
	Registra		JAN 12	2004	quera		Spa	eks							

/Medical Examiner or Attanding Physicien: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, After death. within 24 hours after death To the Funeral Director: / completely filled in by the f To the Hospital within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic avent, the Mudical Example once.

Physician

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

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Be Completed

Certification: To

Medical

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Manyland

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death

hyporto	18.00		1 Yes 2	No 3 Probably 4 NUnknown	
agetic	anesays		24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical		26. Place of Death (C	Check only one)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: Inpalient 2 ER/Outpatient 3 DOA	e 5 Residence 6 Other (Specify)			
27. Manner of Peath 1. Natural 5 Pending 2 Accident investiga	(Month, Day Year) Injury	Injury at Work? 1 Yes 2 No	I. Describe how injury	occurred	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Physician: To the best of my knowledge, death occurred at taminer: On the basis of examination and/or investigation, in and manner stated.				

State Registrar

Loved 31. Date filed (Month, Day, Year) JAN 1 6 2004

29b. Signature and title of certifier

mercen 32. Registrar's Signature

WD

address of person who completed cause of death (Item 23a) (Type, Print)

Sporks"

29d. Date signed (Month, Day, Year)

10,2004

January

B

		1 - For State Registrar	State of Ma		epartmer Certificat			and Mental F	lygiene Reg. No.	1004	02462
		1. Decedent's Name (First, Middle, Last)						2. Date of Month	Day	Year	3. Time of Death
Physic /Med		Effie H. Creamer						Janua		2004	2:05 P ^M
Exami	ner	4a. Facility Name (If not institution, give s					Location o	f Death		County of Death	
		Shady Grove Adventist 5. Social Security Number 6. Sex		ne (In yrs. last birthe		kvil	If Under 2	24 Hrs. 8 Date of		ntgomer 9. Birth	y place (State or Foreign
Funeral Director			M 2½∏F	89 Yr	Months	Days	Hours	Min. (Month,	Birth Day, Year) 8, 1914	Cou	yland
		Usual Residence of Decedent									
irylan show	_	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
8a-f.	cto	Maryland Montgomery	7	Germant		0.4.			10a Citia	en of What Cou	
vith th	Dire	10e. Street and Number 13026 Shadyside Lar			10f. Zij	874				ted Sta	
eath ve 23g	erai		12. Was Decedent E	ever in U.S.			ispanic Orio	gin? (Specify Yes or		4. Race - Ameri	
the state of the s	Funeral Directo	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes, spe	cify Cuba	in, Mexican	, Puerto Rican, etc.		Black, White	, etc.
urs a	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 LJ Yes	21XI No	Specify:			Specify: W	hite
72 ho	Completed by	15. Decedent's Educ	cation completed)	(ecedent's Usu Give kind of wo	ork done	durina most	of working	16b. Kin	d of Business/Ir	ndustry
od within 72 hours aff gjene. er then "natural", or itte Medical Exem.	nple.	Elementary/Secondary (0-12)	College (1-4or 5	+)	ife. DO NOT L		1)		0	11	
led w lygier her ti	ဒီ	10 17. Father's Name (First, Middle, Last)		HO1	memaker		18 Mothe	r's Name (First, Mic		n Home	
h be fi	Be	William Edward Conr	ne11v					er Henrit			
hould Me mark	2	19a. Informant's Name/Relationship (Type		19b. I	Mailing Addres	s (Street		r or Rural Route Nu			ip Code)
id 2 s lith an 27 is trau	1	Claudia Mae Crown/						ne, Germa			
t Hea Hea Item		20a. Method of Disposition		20b. Place of D	Disposition (Na	me of		Date		cation - City or T	
Se = 5\C		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other_(Specify)	emoval from State	Memori	crematory or arklawn al Park			January 14 , 2004	Rock	ville.	Maryland
permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: It item 27 is marked oth any injury or other traumatic event		21. Signature of Funeral Service License	M606		22. Name a	nd Addre	ss of Facilit		. Pump	hrey Fu	neral Home
Physician		23a. Flant Enter the disease, or compliant shock of heart failure. List only or Immediate Cause (Final disease or condition	cations that caused ne cause on each lin		et enter the mo	de of dyir	ig, such as	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
cate be executed by physicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Uniderlying Cause (Disease or injury that initiated events resulting in death) Last		E a consequence of a consequence of							
that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	Fetal death 3 Ectopic pregnancy					3d. Date of delik	very Day Year
law requires that as been signed b	þ	Part II. Other significant conditions con	ntributing to death b	ut not resulting in	the underlying	cause giv	en in Part I		oid tobacco us		the cause of death?
The law requires t ate has been signe page 2 should be	Completed							a	Vas an utopsy enformed?	prior to o death?	topsy findings available completion of cause of
p le d		25. Was case referred to medical					OC Disease	1 Y		1 L Yes	2 □ No
Bici	o Be	eyaminer?	lospital:	ent 2 ER/Out	patient 3 🗆 D	OA Ott	or:	of Death (Check o		Other (Spen	ufv)
P P Sile	I	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da			28c. Injur Wor		28d. Descr	ibe how injury		,
or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.		At home, farm, street, factory, office 28f. Location (Street and Number of Rural Route Number,						
To the Hospital of within 24 hours at To the Funeral D completely filled in	edical C	29a. Certifier (Check only one) 1X Certifying Physical Exemi		f examination and							
To the within 2 To the complet	Me	29b. Signature and title of certifier	7		25		e number			e signed (Month	
3			1120	M	1)	D58	597		Janu	ary 9,	2004
		30. Name and address of person who co									
			M.D. 8609		1 /			B, Silver	Sprin	g, MD 2	0910
Regis	tate strar	31. Date filed (<i>Month, Day, Year</i>)		ar's Signature	9 Sp	ark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** Joanne S. Culler ΡМ 10, 2004 7:30 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3523 Olympic Street Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Director 77 577-32-3982 July 13, 1926 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20906 3523 Olympic Street USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Black White etc 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural". Completed Department of Health and Mental Hygiene. Instumingoriant: If item 27 is marked other than "natum any injury or other treumetic event, the Medical and injury or other treumetic event, the Medical ones. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Homer Jackson Smith Florence Sylvia Carrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank W. Culler/ Husband 3523 Olympic Street, Silver Spring, MD 20906 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State cemetery, crem Parklawn Memorial January 14 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 □Donation 5 □Other (Specify) 2004 Rockville, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Michen MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning to manage cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aryotrophic Lateral Sclerosis Examiner The law requires that the death certificate be executed burial-transil Due to (or as a consequence of) Physician/Medical as the t IF FEMALE use 23c. If yes, out*co*me of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year signed by the at t be detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

Baltimore, Maryland 21215-0036

Box 68760.

P.O. I

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

JAN 13

31. Date filed (Month, Day, Year)

Nasreen M. Kango M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7610 Carroll Avenue, Takoma Park, MD 20912

January 12, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001. For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 0505AM 2004 01 EVAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NEWYO MONTGOMERY m B MONTGORERY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 3 M 2 □ F 2-13-56-5439 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic svent, the Medical Examinat must be usuffiled at any price. 1 ☐ Yes 2 No Funeral Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 USA 12320 Quail Woods Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 21 No Baltimore, Maryland 21215-0036 Specify: Specify: White φ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Handyman Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marjorie Griffin Evan H. Davis, Jr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Coach House Way, Unit 2A, Frederick, MD 21702 Evan H. Davis, Jr/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 15 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 2004 Alexandria, Virginia Metropolitan Crematory Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Kein Stile Approximate Interval Between Onset and Death 23a. Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HEDATOCELLULAR CARCING-UNG /Medical Due to (or as a consequence of): Examiner CLZROHSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown ieral Diractor: After this certificate has been signed lifilled in by the funeral director, page 2 should be det Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BACTERIUZ PERLITUNITIS 1 Yes 2 No 3 Probably 4 Noknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 8 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Mnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deati To the Funeral Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminers On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) undy Grave Rd #103 Parkville MDZcaso COLLIER 15225 PATRICK KEVIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 6 2004 Registrar

		1 - For State Registrar	State of M	1arylar		artment <i>rtificate</i>					giene (Reg. No.	2004	0246
		1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea	ith Day	Yeer	3. Time of Death
Physic /Medi		Virginia F. Del	Lahaye							January		2004	4:08am ^
Examir		4a. Fecility Name (If not institution, give		r)		4b. City, To	own, or	Location of	of Death	•	4c. C	ounty of Deat	h
		Suburban Hospital				Bethe			0411-			ntgome	
Funeral		5, Social Security Number 6. S	9x 7.A □M 21XTF		last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day	, Year)	9. Birtl	nplace (State or Foreig untry)
Director		411-36-0330 Usual Residence of Decedent		76	115.					Feb. 4,	192	/ Arka	ansas
and w		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limit
Mary f eth	ō	Maryland Montgome	rv	Mo	ntgome	ry Wil	120	Δ.					1 ☐ Yes 21 N
28a	Directo	10e. Street and Number		110	педоше	10f. Zip C					10g. Citize	n of What Co	untry?
3a or	ā	19323 Clubhouse Ro	nad #101			2088	6				Unit	ed Stai	tes
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "natural", or Itams 23a or 28a-f show event, the Medical Exatring must be motified at	Funeral	11. Marital Status	12. Was Deceden		.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian,
after or Ita	Ē	1 Never Married 2 Marned	Armed Forces 1 Tyes 2 The lift Yes, Give			1 Yes 2		Specify:		rricall, etc.)		pecify:	5, 610.
ral', c	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates	:		103 24		Opouny.				W	hite
72 h	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usual kind of work DO NOT use	done d	ition <i>lunng m</i> os	t of worki	ng	16b. Kind	of Business/	ndustry
within ene.	I du	Elementary/Secondary (0-12)	College (1-4o	r 5+)									
e filed within at Hygiene. I other then '		12 17. Father's Name (First, Middle, Last)			Kesia	ent Ma	nag		ar's Name	(First, Middle,		artment	
be fi	Be											,	
should be nd Mental marked umatic ev	٦	Donald Ray Fentor 19a. Informant's Name/Relationship (19h Maili	na Address /	Street a			oberts al Route Numbe	r City or i	Town State Z	(in Code)
12 st h and 7 Is r traur			_			1000							
es 1 and 2 should b of Health and Ment f Item 27 Is marked ir other traumatic e		Gina Hinden (Daugh 20a. Method of Disposition	iter)	20b. I	Place of Dispo	sition (Name	of			Gaither		tion - City or	
H It		1 ☐ Burial 2 【XCremation 3 ☐		8	cemetery, crei			4	. 1/1	2/0/	. 1	1	T7 1
ritmer ritmer		* 4 □ Donation 5 □ Other (Specifical Service Licental Se		Me	tropol	ltan C	rem	atory	v De	3/04 Vol Fun	Alexa	andria, Home	Virginia
permit. Pages I Department of H Importent: If Ite any injury, or ot once.	1	21. Signature de vice de la constante de vice de la constante	12 2 Mel		-	10 Eas Gaithe	t D	eer P	ark	Vol Fun Drive			
		23a Part1 Enter the disease or com	nlications that cause	ed the dea							rest.		Approximate
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	€										Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	d		CLER	-0110	- }	-CEA	27	Diser	TSE		4CZARS.
Examiner			Due to (or a	is a consec	quence or):								
4	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a consec	quence of):								
sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events	C										
be executed icien and burial-transit		resulting in death) Last	Due to (or a	is a consec	quence of):								
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rtifica ng ph as th	8	IE COMIC	-							-	- 1		
death certifice e attending ph id for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1☐Live birth			☐Ectopic pre	nancy				23	d. Date of deli Month	very Day Year
	sicie	in the past 12 months?	4☐ Pregnant 9☐ Unknown		death 5[Other (spec	city)					MOUTH	Day 1 out
at the de by the a	h	9 Unknown								OZ- Did M			the cause of death?
requires that the seen signed by th hould be detache	by	Part II. Other significant conditions of		but not res	sulting in the u	inderlying cat	ise give	en in Parti	•		_		obably 4 DUnknow
w requir been si should	ted	RENAL FA	ILUPE					•		1 🗆 Y	85 2139		
aw as t	Completed	LEFT LEG	CELLI	ンレしてい	<u>S</u>					24a. Was autop	sy	prior to d	topsy findings availab completion of cause of
ate pa	50										med?	death? 1 ☐ Yes	2 No
Physician: T this certificat ral director, pi	Be (25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
hysic this co	ှင	1 □ Yes 2 ☑ No	Hospital: 1 🖸 Inpa		ER/Outpatie		0.00	4 140	-	me 5 Resid			cify)
	i.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, L	ijury Da <i>y Year)</i>	28b. Time o Injury		C. Injury Work	(?		28d. Describe h	low injury	occurred	
Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b				М		Yes 2□		206	· · · · · · · · · · · · · · · · · · ·	Alimbara an Oi	Control North Control
l or Ati after d Direct I in by	Certification;	4 Homicide determined	200. Flace of 1	etc. <i>(Speci</i>	ome, tarm, st fy)	reet, tactory,	office			City or Tow		Number or Hu	ral Route Number,
To the Hospital or, within 24 hours after To the Funeral Directory Completely filled in E		00 0 0 dilin 45 45 45 5	velajes Tarta t	ot of my l-	nudadan da	th operated at	the to	o deta a	od place	and due to the	20100/-1	nd mena	ctated
Hosi 24 ho Fune fely fi	edical		ysician: To the bearing of the basis and manner	of examina									
thin 2 the mple	Med	29b. Signature and title of certifier	and manner	stateu.		29c.	License	number			29d. Date	signed (Month	n, Day, Year)
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>					m 03a) /T		-						
		30. Name and address of person who	50 W	Solu	1 20a) (1ype,	UN Dr	ive	A	401	. Roc	huil	10 M	0.20852
- 01			32. Régis	strar's Sign	ature /	-							
St Regist	ate	31. Date filed (Month, Day, Year)	32. Régis	strar's Sign	ature 4	do	eks						

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1-11-04 040

DELAMAGE, VIRGINIA

			For State Registrar		rtment of Health and I		ene 2004 g. No.	02466
			1. Decedent's Name (First, Middle, Last)			2. Date of Death : Month	Day Year	3. Time of Death
	Physicia /Medic	_	FAYE ARLENE DO			JANUARY	13, 2004	2051 1
	Examin		4a. Facility Name (If not institution, give street and n				4c. County of Deatl	
			BROOKE GROVE REHABILIT,				MONTGO	
	Funeral		5. Social Security Number 198 10 3615 6. Sex	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, JAN. 29	Year) 9. Birti 1920 PENI	nplace (State or Foreign untry) NSYLVANIA
	Director		Usual Residence of Decedent	00		JUAN. 29	1920 FLIN	12 I L A HILL
	land ow		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary Hash	ţ	MD. MONTGOMERY	GAITHE	RSBURG			1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	intry?
	death with the Marylar ms 23a or 28a-f show ms be notified at		7520 ELIOAK TERRACE		20879		UNITED ST	ATES
	deat	Funeral		cedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Amer Black, White	
õ	or its		1 Never Married 2 Married 1 Yes	2 Mo Give	☐ Yes 2 🛣 No Specify:		Specify:	WHITE
ğ	hours tural',	d by	3 ☑ Widowed 4 □ Divorced Year or				Sh Kind of Business	
215-0036	"na"	Completed	15. Decedent's Education (Specify only highest grade completed	d) (Give	lent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Business/	ndustry
_	withii ene. than	E C	Elementary/Secondary (0-12) College	(1-4or 5+)	OMEMAKER		OWN HOME	
0	filed Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)			ne (First, Middle, M.		
<u>a</u>	should be filed withir In Mental Hygiene marked other than imatic event, the M	To B	GEORGE BEERS		SADIE	CARL		
Maryland 2	2 should and Menis markers aumatic		19a. Informant's Name/Relationship (Type, Print)	1	g Address (Street and Number or Ru		•	
Σ	and 2 ealth a n 27 is		SUE E. DOLL / DAUGHTER		ELIOAK TERRACE,			20879
ore C	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)		0c. Location - City or	
altimore,	Pages ment of ant: If It		* 4 □Donation 5 □ Other (Specify)				JENNINGS C	HAPEL, MD.
Ball	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Licensee	Par 162 22	MURIEL H. BARBER			
_	40 = # O		23a, Part1. Enter the disease, or complications tha	Jacob Constant	P. 0. BOX 5038,			20882 Approximate
			shock, or heart failure. List only one cause or	each line.		c or respiratory arres	si,	Interval Between Onset and Death
Sper	Physician		resulting in death)	CTERIAL PIN	EUMONIA			DAYS
	/Medical Examiner		Due t	o (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):				
	uted	Examiner						
o,	exec an an rial-tr	Exa		o (or as a consequence of):				
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	d					
9	intificating ph	Med	IF FEMALE:					
Box	eath certific attending pi	an/	23b. Was decedent pregnant 1 Live		Ectopic pregnancy		23d. Date of deli Month	very Day Year
P.O.	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			
	that the	F	Part II. Other significent conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	w requires that the de been signed by the s should be detached	d by	ALZHEIMER'S D	ISEASE		1 ☐ Yes	s 2 No 3 Pr	bably 4 Unknown
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Be Be	sician: The law s certificate has b lirector, page 2 s	шc				autopsy perform	ed? death?	completion of cause of
ta	an: T tificat tor, pa	Be C	25. Was case referred to medical		26. Place of De	ath (Check only one		20110
<u> </u>	ysicii is cer direct	To B	examiner? 1 Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: Nursing H	dome 5 ☐ Resider	nce 6 Other (Spec	city)
0	Attending Physician: r death. ector: Atter this certifics by the funeral director, I		27. Manner of Death 1° ■ Natural 5 □ Pending (Mi	te of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how	w injury occurred	
<u>ত</u>	endir eath. or: Af he fu	atle	2 Accident investigation		M 1 Tes 2 No			
Division of Vital Records,	after danger dan	Certification:	determined 286. Fla	ice of Injury - At home, farm, str ilding, etc. <i>(Specify)</i>	eet, factory, office	28t. Location (Street, City or Town,	eet and Number or Ru State)	ral Route Number,
	Hospital		29a. Certifier Certifying Physician: To	the best of my knowledge, death	n occurred at the time, date and place	and due to the car	use(s) and manner as	stated
	24 hos Fun etely	edical	(Check only 2 Medical Exeminer: On the		vestigation, in my opinion, death occ			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	Me	4.00		29c. License number	29	d. Date signed (Monti	n, Day, Year)
	+		ATTENI	DING PHYSICIA	J D42046	JA	ANUARY 14	,2004
	,		30. Name and address of person who completed ca	ause of death (Item 23a) (Type,	Print)			20360
			GRACE BROOKE HUFFMAN M	D. 18 100 >LAD	E SCHOOL KUAD S	ANDY SPA	4NG, MAR	YLAND
	Sta Registi		31. Date filed (Month, Day, Year) 32	, pegistrar's Signature	Print) ESCHOOL ROAD S	1		

	1	State Registrar	State of Ma	•	artment of H			eg. No.	0246	
Physicia /Medic Examine	an al	1. Decedent's Name (First, Middle, Last) Margaret O Ne 4a. Facility Name (If not institution, give si	reet and number)	Dorn	4b. City, Town, or	Location of I		Day Year		
Funeral Director		217-70-8693	7. Age	(In yrs. last birthday 48 Yrs.		If Under 24			hplace (State or Foreign untry) nington D.C	
a-f show		Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ry	10c. City, Town or L		hesda			10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
ath with the	Funeral Director	10e. Street and Number 6810 Buttermere La				0817		United States 14. Race - American Indian,		
urs after de al', or Items Examiner m	Ď.	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	 Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates: 	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	Black, Whit		
within 72 hours after death with the Maryland ene. than *natural; or Items 23e or 28e-f show he Medical Examiner must be multifued at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) HOmemaker						g 16b. Kind of Business/In		
uld be filed Mental Hygi irked other itic event, i	To Be Co	17. Father's Name (First, Middle, Last) Eugene		Neill		Mar		iffith		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinet must be notified at once.		19a. Informant's Name/Relationship (Typ. Jim O Neill / Brot 20a. Method of Disposition 1 □ Burial 2 🖫 Cremation 3 □ Relationship (Typ.)	her	2725 20b. Place of Disp cemetery, cre	Malvern osition (Name of omatory or other place	Hill C	or Rural Route Number ct.; Davidso Date anuary 3,		21035 Town, State	
permit. Pa Departmer Important any injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Functal Service Uccesses	e k	100382	ke Cremat 2 Name and Addre Kapp Fune 33 Gist A	ss of Facility	2004 d Crematior Silver Spri	Services	0910	
Ate be executed /Medical /Medical Examiner / Medical Fransit Medical / M	cal Examiner	d								
death certifica e attending plad for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown		23d. Date of delivery Month Day Yea					
The law requires that the to the bas been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4		
	Completed							24a. Was an autopsy autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings ava prior to completion of caus death? 1 □ Yes 2 ☑ No		
r Attending Physicien: ler death. Irector: After this certific by the funeral director.	25. Was case referred to medical examiner? 1							only one) Residence 6 □ Other (Specify) cribe how injury occurred tion (Street and Number or Rural Route Number, or Town, State)		
Hospitel o 4 hours af Funeral D iely filled ir	Medical Cert	29a Certifier 1X Certifying Phys	sicien: To the best of	of my knowledge, des	ath occurred at the ti	me, date and opinion, death	place, and due to the o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)	
To the within 2 To the complet	Mec	29b. Signature and title of certifier 30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type		D35859)		th, Day, Year) 8, 2004	
Sta Registr		Leszek Karowiec, M 31. Date filed (Month, Day, Year) JAN 12 200	32. Registra	ar's Signature	Spark.		phriig, m	D 20910		

MARGARET

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For Registrer	State of Maryland	/ Depa		ealth and N	lental Hygi	_	. 021	. 6.9		
	ы	1. Decedent's Name (First, Middle, Last,	,				2. Date of Death		3. Time of	Death		
Physicia /Medic		CANDACE	L. [OOWNI	NG 4b. City, Town, or	Location of Death	January	Day Year 10, 2004 4c. County of De	7:00	P M		
Examin	er	4a. Facility Name (If not institution, give			•	LOCATION OF DOGIN		,				
	-	Montgomery Gener		hirthday)	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montg	irtholace (State or	Foreian		
Funeral Director		0. 000	M 2⊠F 12	Yrs.	Months Days	Hours Min.	June 11	1991	Marylan	d		
ō		Usual Residence of Decedent	1.0 0: 3						10d. Inside Cit	. I Insite		
how		10a. State 10b. County	10c. City, T						1 Tes			
Ba-f	ct Ct	Md. Montgo	mery La	yton	sville							
death with the Marylan ms 23a or 28a-f ehow r must be notified at	Director	10e. Street and Number 5712 Stanbrook L	10f. Zip Code	20882		Citizen of What Country? United States						
s 23	Funeral		12. Was Decedent Ever in U.S.	13.1	Was Decedent of Hi		ecify Yes or No-	14. Race - Am				
iten de Item	Š	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	i i	Was Decedent of Hi f Yes, specify Cubai		Rican, etc.)	Black, Wh				
urs at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			Specify:	Specify:	White				
2 ho	Be Completed		15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv				edent's Usual Occupation e kind of work done during most of working DO NOT use retired)					
thin 7		Elementary/Secondary (0-12)	College (1-4or 5+)				Cohoo 1					
ed wi		7	0	St	udent	40. 14-15-1-1-1-1	- (First Adidate Ad	School				
d offi		17. Father's Name (First, Middle, Last) Andrew G. Do	wning			Mathy	e (First, Middle, Ma Millind					
Men Men Marke	2			401 14 10					Zin Codol			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hydiene. Department of Heath and Mental Hydiene. Bental It is marked other than "natural; or items 23a or 28a-f show eny injury or other traumatic avent, it is Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (T) Andrew G. Downing		5712	ng Address <i>(Street a</i> Stanbroo	k Lane,	Laytonsv	ville, Md	20882			
1 an Heall sm 2		20a. Method of Disposition		e of Dispo	sition (Name of matory or other place	-1	Date 2	Oc. Location - City of	r Town, State			
8 5 5 9 6 8 8 9 8 9 8 9 9 9 9 9 9 9 9 9 9 9 9		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State Mots	ropol	itan Crem	". 1/1	2/04	Alexandr	ia, Virg	inia		
artme ortar injur		21. Signature of Funeral Service Licens		22	Name and Addres	s of Facility	Euponal F	loma				
De de de de de de de de de de de de de de		> murief &	11- Burher	ノ i i i	P. O. Bo	x 5038.	Lavtonsv	ville, Md	. 20882			
		23a, Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the death.						Approximate Interval Betw	veen		
Physician		Immediate Cause (Final	To Caddo Off Cadif Milo.	7100	5 0 1E				Onset and D	eath		
/Medical		disease or condition resulting in death)	a. Due to (or as a consequer	nce of):	7000							
Examiner		Sequentially list conditions, b. Due to (graph a consequence of).										
D =	ner	thank lating to immediate cause. Enter Underlying Due to (or as a consequence of):										
ocute ind trans	Examiner	Cause (Disease or injury that initiated events c. The sulting in death) Last Due to (or as a consequence of):										
be executed sician and burial-transit												
leath certificate b attending physic I for use as the b	dlcal											
certificate nding phys	Me	IF FEMALE:	23c. If yes, outcome of pregnance	v				23d. Date of d	alivani			
death o	lan	in the past 12/months?	in the past 12 ments? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Proposal at time of death 5 Other (specific)							Month Day Year		
0 0 5	Physician/Medi	1 Yes 2 TNo 9 Unknown										
requires that the reen signed by th hould be detache												
quires n sigr ald be	d by											
law rec as bee 2 shou	Completed	24a. Was an 24b. Were autopsy findings av										
0 - 0	H _O						autopsy performe	ed? death	completion of ca s 2 \sum No	use or		
ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Deat	th (Check only one	1				
Physician: this certific ral director.	To B	examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ EP	VOutpatier	nt 3□ DOA Othe	er: 4 🗆 Nursing Ho	ome 5 🗆 Residen	ce 6 Other (Sp	ecify)			
ig Phys ter this neral dir		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 28	Bb. Time o	f 28c. Injury Work	at (?	28d. Describe how	injury occurred	, //	-		
auth. or: Af	atlo	2 Accident investigation	1/10/04	UM	M 101		July eig	range	d self			
al or Attending P s after death. I Director: After t d in by the funera	Certification:	3 Suicide 6 ☐ Could not be determined	28. Place Injury - At home building, etc. (Specify)	e, farm, sti	reet, factory, office	1	28f. Location (Streetly or Town,		Rural Route Numb	oer,		
ital o rrs af rai D	S			TI	tomes		31123	auth rook	e lin or	088-		
ns Hospital or Attendi n 24 hours after death. ne Funeral Director: A pletely filled in by the fo	edical		rsician: To the best of my knowle iner: On the basis of examination and manner stated.									
To the Host within 24 ho To the Func completely f	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	296	d. Date signed (Mor	nth, Day, Year)			
F × F O			Po para			O.C.M.E		anuary 11				
1		30. Name and address of person who c	ompleted cause of death (Item 2	3a) (Type	Print)			-4				
		30. Name and address of person who co	WE MID	ou, (rype,	111 Penn s	Street, E	Baltimore	, Marylan	d 21201			
Sto	ite	31. Date filed (Month, Day, Year)	2. Registrar's Signatur	0 4	South	/		1777				
Poniet	-24	IAN 13 20	Ila Bener		KHUBEROS	1						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 11:12 A^M 2004 January 8, G. Drexler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F 14, 1929 74 Director 071-22-7379 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ritied within 72 hours atter death with the Marylan Hygiene Hygiene Hygiene Than "naturel" or Itema 23s or 28s-1 show ont, the Medical Examinan man be multimed at 1 ☐ Yes 2 ☑ No Director Great Neck New York Nassau 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 11021 6 Deepdale Drive Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates: Specify: 4 White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaking Homemaker and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any injury or other traumatic events. Ge1band Yetta Chajes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7900 Van Gogh Court, Potomac, MD 20854 Kenneth Drexler, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 2 Cremation 3 Removal from State Jan 11, 2004 Pinelawn, NY ` 4 Î Donano 5 Other (Specify) Wellwood Cemetery 21. Signature of Funeral Service Dicens 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Jours 1001 Rockville Pike, Rockville, MD Approximate Interval Between Onset and Death 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Immediate Cause (Final HOURS **Physician** CARDIOGENIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 24 HOURS ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner YEARS CORONARY ATHEROSCLEROSIS The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 □ No 3 Probably 4 □Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has certificate 1 Yes Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: L₀ 1 🔯 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred filled in by the funeral 27 Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation Injury Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a To the Funeral (1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the th 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 MD41507 put Daver ancy **JANUARY 8, 2004** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JAN 12 2004

M.D.

NANCY DAVDNPORT,

32. Registrar's Signature

3301 NEW MEXICO AVENUE, NW

WASHINGTON, DC

Baltimore, Maryland 21215-0036

Box 68760

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Records,

of Vital

Division

Farrah M. Fox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #5 per In G023 2/20/04 Las

State of Maryland / Department of Health and Mental Hygiene

1- State Unpend Items 23a,b,27,28a-f per ME,G828,02/13/04dlab

Reg. No.

Reg. No. 04-0198 AKG 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Farrah Marie Fox 6:58 January 8, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 🔀 F Yrs. Director Maryland unknown 2003 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Dorchester Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5307 First Street 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 9 δ Specify: 3 Widowed 4 Divorced White 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Never Employeed None marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be 1 Mental I Ryan Daniel Fox Melissa Dawn Tubman of Health and Nitem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ryan Daniel Fox/Father 5307 First St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State EastNewMarketCemetery 1/12/2004 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Funeral Home, Raller ONCLUCE/308 High St., Cambridge, MD Approximate Interval Between Onset and Death 23. Page Enter the disease, or emplications that suised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Districtly only one cause on each line. Immediate Cause (Final disease or condition Asphyxia Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Over1ay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed Due to (or as a consequence of) attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy ò Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.0. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2V No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Xes 2 No 24a. Was an autopsy performed? 1 X Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 □ No ျှ 1 Inpatient 2€P/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Attending 5 Pending Fouriday 5:55a 1 Natural Bed Sharing with Adult Found 1 Yes 2 No investigation 2 XAccident 1/3/04 hours after death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ō 5307 First St., Cambridge, MD 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one)

State

within 2. To the I

2

31. Date filed (Month, Day, Year) 32. Registrar's S

e and address of person who completed cau of death (Item 23a) (Type, Print)

JAN 1 3 2004

29b. Signature and title of certiller

32. Registrar's Signature

Registrar

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 9, 2004

111 Penn Street, Baltimore, Maryland 21201

		•	For State Registrar	State	of Marylan		artment of H		d Mental Hy	giene	Managery C	02471
			Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
	Physicia		Caroline M. Fai	rhanks					Januar	y 8, 20	Year 04	11:45 A M
	/Medic Examin		4a. Facility Name (If not institution		ımber)		4b. City, Town, or	Location of Di		4c. County		
	LAGIIIII		Morningside Ass	isted Li	<i>t</i> ing		Ellicott	City		Howar	d	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 h	Irs. 8. Date of Bir	th	9. Birth	place (State or Foreign
	Director		216-60-3320	1 □ M 2 🂢 F	87	Yrs.	Months Days	Hours M	Feb. 1	3, 1916	0kla	intry) ihoma
	D.		Usual Residence of Decedent									
	rylar	_	10a. State 10b. County			y, Town or Lo					j	10d. Inside City Limits
	Ba-f s	cto	Maryland Howard		E11	icott	City					1 ☐ Yes 2 ☑ No
	or 26	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen of	What Cou	intry?
	23a	la [5530 Dorsey Hal	1 Drive,	#331		21044			United :	State	es
	ems erru	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in U orces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	isp <i>a</i> nic Origin? ın, Mexican, Pu	? (Specify Yes or No Lerto Rican, etc.)	14. Rad Blad	ce - Ameri ck, White,	ican Indian, , etc.
9	or it	by Fu	1 Never Married 2 Marr	If Yes, G			1 ☐ Yes 2X No	Specify:		Specif	v: Whi	ite
21213-0030	within 72 hours after death with the Maryland ene. Itan "natural", or items 23a or 28a-f show the Maulical Examitter matche motified a	d b	3 ₩idowed 4 □ Divorced	Year or	Dates:	160 Dans	danka Harri Oran	-1:		405 Kind of B		-4
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N 0	I be filed within ntal Hygiene.	Ö	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle			
Jana	d be	o Be	Robert N. McMil	1en					McCants		•	
5	hould d Me mark mati	2	19a. Informant's Name/Relations			19b. Mailii	ng Address (Street		Rural Route Numb	er City or Town	State Zi	in Code)
Ma	th are the trau		Joseph M. Fairb						Columbia			
a)	1 an Heal em 2		20a. Method of Disposition	anks/ Jun	20b. F	Place of Dispo	sition (Name of			20c. Location		
ᅙ	O = 10		1 ☑ Burial 2 ☐ Cremation				ted Methodi	st Jan	nuary 14, 004	Potomac	. Ma	rvland
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydjene. Department of Health and Mental Hydjene. Department of Health and Mental Hydjene. Any injury or giten 27 is marked other than "natural", or ttems 23a or 28a-1 show mary injury or giter traumatic event, the Marylan Examinar or dat be nutified any once.		* 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service		Chur	ch Ceme	etery Name and Addres	. —				
n n	Deperment of the permet of the perment of the permet o		15 M	599	M013	46 Ro	ckville, ckville.	Inc. 3 Marvla	00 West M nd 20850-	ontgomen 2805	ry Av	neral Home/ Venue
	3		23a. Part1. Enter the disease, or shock, or heart lailure. List	complications that		h. Do not ent	ter the mode of dyin	g, such as card	diac or respiratory a	rrest,		Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):						
	Examiner			_b Lung	Mass							
	\$ ⁷	Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initially even injury	Due to	or as a conseq	uence of						
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Ď,	en ar		resulting in death) Last	Due to	(or as a conseq	uence of):						
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X OZ	death certific e attending p od for use as	an/I	23b. Was decedent pregnant in the past 12 months?		itcome of pregna birth 2 Peta		Ectopic pregnancy				te ol deliv	
	0 0 0	slcl	1 ☐ Yes 2 🔀 No	4□Preg 9□Unk	nant at time of d	leath 5	Other (specify)			Mid	nth	Day Year
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2	w require been si should b	ted	Aortic Stenosis		-				_ 'U	Yes 2□No	3 Prol	bably 4 Unknown
Records		Completed	Chronic Obstruct	ive Pulmo	onary Di	sease			24a. Was	DSV	Were auto	opsy findings available ompletion of cause of
	The law cate has page 2 s	Cou							perfo		death? 1 🗌 Yes	2 No
VIII	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?						Death (Check only o			
0	Physic this c	မ	1 ☐ Yes 2 No			ER/Outpatier			g Home 5□ Resi			Assisted Livin
	Ing P	on:	27. Manner of Death 1 Natural 5 Pendin	28a. Date (Mo	ol Injury oth, Day Year)	28b. Time o Injury	Worl	k?	28d. Describe	how injury occur	red	
Sic	Attending ir death. ector: After by the fune	cati	2 Accident investig	not be				Yes 2 □ No				
UNISION	if or Attendir after death. Director: Al d in by the fu	Certification;	4 Homicide determ	ned 200. Flat	e of Injury - At hi ling, etc. (Specif	ome, farm, sti (y)	reet, factory, office		281. Location (City or To		er or Run	al Route Number,
	pital ours a sral C		20a Codilias - AT Codilia	- Dhugisian T	a bast of a chi	dawl== :		- Caralletta	4	44, 721	10-	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifyin 2 Medical	Examiner: On the	e best of my kno basis of examina nner stated.	wieage, deat ition and/or in	n occurred at the time vestigation, in my of	ne, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) and ma date and place,	inner as s and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of pertified	~			29c. License	e number		29d. Date signe	d (Month,	Day, Year)
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	12	i	30. Name and address of person	who completed so:	se of death (line	n 23a) /Tuna		7014	,	741.041	7 7	1, 200 1
	111		Randal P. Riese				,	#200.	Columbia.	MD 2104	44	
	Sta	te	31. Date liled (Month, Day, Year)	32.	Begistrar's Signa							
	Registr		15N 12	2004	Energy	B	Sparks	distribution of the second				

			1 - For State Registrar	State of	Maryla				ealth a	ind M		gien	20114	. 0	2472
	Physici	20	1. Decedent's Name (First, Middle,	Last)							2. Date of De.	ath Da	ıy Year		ime of Death
	Physici /Medi		Rose Ann Forema	.n							Januar				6:25A M
2/2	Examir	er	4a. Facility Neme (If not institution,				4b. City	, Town, or	Location of	f Death		40	. County of Dea	ath	
			Wilson Health C					ither	sburg				Montgor		
П	Funeral			3. Sex 7 1 ☐ M 2 🖾 F		s. last birthday)		Days	If Under 2 Hours	Min.	Date of Birt (Month, Da	y, Year	9. Bi	rthplace (Sountry)	State or Foreign
45	Director		552-64-7327 Usual Residence of Decedent		9.	5 Yrs.					April 2	23,	1908 Wi	scons	sin
	land ow		10a. State 10b. County		10c. C	ity, Town or Le	ocation							10d. Ins	side City Limits
	Many f sh	to	Maryland Montgom	erv	G.	aithers	hura							1	∑Yes 2 No
	the 28a	Director	10e. Street and Number			arener 5		p Code				10g. Ci	tizen of What C	ountry?	
	3a o	0	301 Russell Ave	nue			20)877					ted Sta	•	
	deatl	Funeral	11. Marital Status	12. Was Deced			Was Dece	dent of Hi	spanic Orig	in? (Spe	cify Yes or No		14. Race - Am	erican Ind	ian,
ထွ	after or Ite	T.	1 Never Married 2 Married	Armed Ford 1 Tyes 2 If Yes, Give	№ No		1 ☐ Yes		n, Mexican, Specify:	, Puerto F	tican, etc.)		Black, Whi	ite, etc.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28e-f show i.e Medical Exertirer must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Date	es:		10 105	2 <u>A</u> 1 140	зреспу:				Specity: W	nite	
<u>5</u>	72 h	Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Dece (Give	dent's Usu kind of wo	al Occupa	ition <i>Juring</i> most)	of workin	g	16b. K	and of Business	/Industry	
7	withir ne. then	d E	Elementary/Secondary (0-12)	College (1-4	lor 5+)			ise retired,)			_			
2	Hed y		17. Father's Name (First, Middle, La	4		Teac	ner	-	19 Mothor	r'a Nama	(First, Middle,		blic Ed	ucat	ion
auc	ad be fad and of	Be										Maiger	i Sumame)		
Ž	hould d Me mark matic	2	Louis J. Marsh. 19a. Informant's Name/Relationship			10h Maili	na Addros	(Ctroot o		a Hai		- 01	- T O1	7: 0: (1)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or Itema 23s or 28s-1 show may no lury or other traumatic event, Ite Medical Evertimes must be notified at once.					1							or Town, State,		
ē,	1 an Heal tem 2		Elsa L. Leonard	Daugnter	20b.	Place of Dispo	sition (Na	me of	1		N.W., W		ington,		
<u></u>	ages int of t: If I		1 Burial 2 1 Cremation 3		ate Mo	cemetery, crei ntgomen ematori	matory`or o ĈV	other place	0.0	anuar	y 15		,		
Baltimore,	artme a	- 77	4 □ Donation 5 □ Other (Spe21. Signature of the ral Service Lice		Cr	emători	Lum,	Inc.		004 Robe	art A	Bet	thesda,	Mary	land
Ba	Dep de la la la la la la la la la la la la la		1 :05	Δ	MOC	803 R	ockvi	11e,	Inc.	300,	West	ont	gomery .	Aveni	al Home/ ie
r	2		23a. Part1. Enter the disease, or co	omplications that cau									05		ximate
	Physician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. PN	EUM	AINC								Interv	al Between and Death
	Examiner		1	Due to (or	as a conse	quence of):									
		- G	Sequentially list conditions, if any, leading to immediate	b	as a conse	quence off.									
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury												
,	exect n and ial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or	as a conse	quence of):							-		
760,	ate be executed hysician and the burial-transit	cal		d											
9	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ba		<u>.</u>								-			
ŏ	eath certific attending p	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco)C-+						23d. Date of de	livery	
m	deat	icla	in the past 12 months? 1 Yes 2 XNo	1□Live birtl	t at time of]Ectopic pr] Other <i>(sp</i>					1	Month	Day	Year
о. О	at the de by the a tached	hys	9 🗆 Unknown	9□ Unknow	n ————————————————————————————————————										
	w requires that been signed b should be deta	by F	Part II. Other significant conditions	contributing to deat	h but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco ı	use contribute to	the caus	e of death?
ğ	en si								_		1 □ Y	es 2	□No 3□Pr	obably	4 DUnknown
ecords,	aw re as be 2 sh	Completed									24a. Was a		24b. Were au	topsy find	lings available
T	The lav	E O									autops perfor	med2	death?	completion 2 No	n of cause of
Vital	ician: Th certificate rector, pag	۵	25. Was case referred to medical						26. Place o	of Death	Check only or	2 No	10,163	21,111	,
	g 5	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 Inp	atient 2	ER/Outpatien	t 3 DC	Othe				-	6 □Other (Spe	cifv)	
l of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I	njury Day Year)	28b. Time of Injury	2	8c. Injury Work	at		d. Describe h			- 77	
<u>S</u>	a i a	atic	2 Accident investigat	ion	,,	inquity	М		es 2□No	0					
Division	er de recto	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad 28e. Place of	Injury - At h	ome, farm, str	eet, factory	, office		28	If. Location (Si City or Town		d Number or Ru	ıral Route	Number,
	ital o	Cer								Į.	Ony of Your	i, Giaio	,		
	the Hospital or Attending hin 24 hours after death. tha Funeral Director: Afte npletely filled in by the fune	ical	(Check only 2 Neurical CX	Physician: To the be aminer: On the basi	st of my kno	owledge, death	occurred estigation	at the time	e, date and	place, an	d due to the c	ause(s)	and manner as	stated.	usa(s)
	To the Hospital or Atte within 24 hours after de To tha Funeral Directo completely filled in by th	Medical		and manner	stated.										
•	or Too		29b. Signature and title of certifier	1 Bruw				License		2			e signed (Monti	n, Day, Ye	2001
	18			40			1		156			N	VARY 1	1,0	wy
	,		30. Name and address of person wh	ER MD,			LL A	HEV	UUE	GA	THER	s B	irg up	20	877
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Sign	A S	do	uki.	*						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene of the All Copies Are Legible.

			State of Marylai	Certific			F	Reg. No.	004	0247	3
	Physician /Medical	Decedent's Name (First, Middle, Last Marjorie	Isabelle	Goff			2. Date of Dee Month January	Day	Year 2004	3. Time of Death 2:15PM	
Ì	Examiner	4a Fecility Neme (If not institution, give Manor Care of Pot			4	b. City, Town, or Potom	Location of Death	4c. Count	y of Deeth		
	Funeral Director	5. Social Security Number 6. Se 038-05-1230		. iast birthday) If Ur Yrs. Mont	nder 1 Year ths Days	If Under 24 Hrs Hours Min.	8. Date of Birth	, Yeer)	9. Birthpla Count	y ace (State or Foreig ry) de Island	
	Marylend a-f show fred at	Usuel Residence of Decedent 10a. State 10b. County D • C • N/A		ty, Town or Location						od. Inside City Limit	ts
	ofter deeth with the Ma or thems 23a or 28a-1 a river must be notified Funeral Director	10e. Street end Number 2307 41 Street N.	W. #101	10f.	Zip Code 20007		1	Og. Citizen of United		•	
020	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: If them 27 is merited other than 'naturel', or thems 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		ecedent of Hi specify Cubar s 21 No		pecify Yes or No- lo Rican, etc.)		ce - America ick, White, e by: White	tc.	
21215-0020	be filed within 72 hours of tal Hygiene. d other than "naturel", of event, the Medical Exart Be Completed by	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	16a. Decedent's L (Give kind of life. DO NO Paraleg	work done d Tuse retired	ition uring most of wo	rking	16b. Kind of 8		ustry	7
Maryland	Mental Hyg Mental Hyg arked other atic event, To Be C	17. Fether's Neme (First, Middle, Last) Ralph	off			18. Mother's Nar Edith	me (First, Middle, I	Maiden Sumar		ic rigericy	
Mary	nd 2 shou alth and M 27 la mer r traumet	19a. Informant's Name/Relationship (Ty Sally Walther (Po		19b. Mailing Addr 3025 On Washing	ress (Street a	nd Number or Ru	irel Route Number	r, City or Town	, Stete, Zip (2ode)	
galtimore,	ment of Her thent: If Item tury or othe	20a. Method of Disposition 1 □ Burial 2 ☑ Cremetion 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Disposition (cometery, crematory) esapeake (Name of or other place)	Date	20c. Location Beltsvi			
Balt	permit. Depertr Importu any Inj	21. Signature of Funeral Service Licens	e J	Rapp 933 G	and Address Funera ist Av	i of Facility I And Ci enue, Si	remation Llver Spr	Servic ing, M	es D 209)10	
	Physician /Medical Examiner	23a Fant. Enter the disease, or combishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Met	h. Do not enter the n	Ca			est,		Approximate nterval Between Onset and Death	
68/60,	requires that the death certificate be executed seen signed by the attending physician end hould be deteched for use as the buriel-trensit eted by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last		or as a consequence of					1		
NOX P		issuming in Goodiny Edist							<u> </u>		
	of the death cert of the attendir of the attendir of the check of the constitution of the check	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlyin	g cause give	n in Part I.				he cause of deeth	
ords, r	v requires that the death cent been signed by the attendin should be deteched for use leted by Physician/N						24a. Was er	n autopsy		e autopsy findings	
9							1 □ Ye		com	pletion of cause beth?	
N 12	r this certific eral director, 1: To Be (25. Wes case referred to medical examiner?	ospital:		Othor		th (Check only one				
	to the negatial of standards Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2. Medical Certification: To Be Compl	1 Yes 2 No 27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	ER/Outpatient 3 D 28b. Time of Injury M	28c. Injury Work?	et Nursing H	ome 5 Reside 28d. Describe ho				
	use or Attending in its after death. al Director: After ited in by the funer. Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specify	ome, farm, street, fact	tory, office		28f. Location (Str City or Town		er or Rural F	Route Number,	
	within 24 hours after to the Funeral Dir completely filled in Medical Cert	29a. Certifier Check only one) Certifying Phys	ician: To the best of my kno- er: On the basis of examinal and manner stated.	wledge, death occurre tion and/or investigati	ed at the time on, in my opi	, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and ma ite and place,	inner as stat and due to th	ed. re cause(s)	
	within within to the comp	29b. Signature and title of certifier.	1-00-00-00-00-00-00-00-00-00-00-00-00-00		29c. License			Date signed			
	•	30. Name and address of person who con Suniter Bhocaile	npleted ceuse of deeth (Item	23e) (Type, Print) Lapa for	ed C	126 230	Tal :	7 . mr)) la	or	
H	State Registrar	31. Dete filed (Month, Day, Year) JAN 1 4 2004	32. Registrer's Signa	ture &	ocks		1000 9	Ly,"	5616	76.	

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 10:40 PM Goldson January Eric Aloysius /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sligo Creek Nursing & Rehab. Takoma Park

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1⊠M 2□F Yrs May 26, 218-11-4735 91 Director Jamaica Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "natural", or Items 23a or 28e-f shov edical Examiner must be notified at 1 □Yes 21 No Directo Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20783 Jamaica 7953 18th Avenue death Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. http://distriction.org/pip.marked.other.than.insturel.orlie ury ocother traumatic event, the Medical Exercities 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: Black Completed by 3 Ø Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Painter/ Wall Paperer Interior Design 8 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be to Oppartment of Health and Mental Hinportent: If item 27 is marked of any injury or other traumatic even once. Selvin Goldson Ethlyn Scott ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Crew/ Daughter 5623 Duchaine Drive, Lanham, MD 20b. Place of Disposition (Name of cametery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition January 17 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD * 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Faculty.
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Spring, MD 209

Approximate Interval Between Onset and Death 21. Signature of Funeral Service License MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pnysician Arrhythmia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached t Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown Parkinson's Disease 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed certificate 2□No 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 🗵 No 은 3□ DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pendina Injury 1 X Natural 1 □Yes 2 □No investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10000 D42518 January 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike, #401, Rockville, MD Dr. G. Chablani 31. Date filed (Month, Day, Year) 32. Registrar's Signature State books JAN 16 2004 Registrar

٥			For State Registrar	State of	of Marylan	•	artment o			nd M	-	giene -	2004	02475
	Physicia /Medic Examin	al	Decedent's Name (First, Middle C + AP2 4a. Facility Name (If not institution)	LES n, give street and nu	mber)	200	MS 4b. City, To			f Death	2. Date of Dea	Day 4c. Ce	Year 2004 ounty of Death	
	Funeral Director		Millennium 5. Social Security Number 220-26-2472 Usual Residence of Decedent	Renab (6.Sex XXM 2□F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 \	rear II	f Under 2 Hours	_	8. Date of Birt (Month, Da) Dec . 5			place (State or Foreign intry) Yland
	the Maryland 28e-f show	Director	10a. State 10b. County	timore	10c. City	y,TownorLo Reis	tersto					10g. Citize	n of What Cou	10d. Inside City Limits 1X Yes 2 □ No Intry?
9	be filed within 72 hours after death with the Maryland nat Hygiene. Id Hygiene. Id other than "netural", or Items 23a or 28e-f show event, I've Medical Ever; if ar must be notified at	Funeral	83 Bond Ave	12. Was Dec Armed F ied 1 _Yes If Yes, G	2⊠ No ive					in? (Spe Puerto F	cify Yes or No Rican, etc.)	- 14	S.A. Race - Ameri Black, White	, etc.
1215-0036	within 72 hours ane. than "netural",	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Deceden (Specify only highe: Elementary/Secondary (0-12) 11th	Year or I	Dates:	(Give	dent's Usual C kind of work o DO NOT use i	done duri retired)	on ing most	of workir	ng	16b. Kind HOW	of Business/Ir ard Co	ndustry
Maryland 2	thould be filed and Mental Hygic marked other matic event, I	To Be Co	17. Father's Name (First, Middle, John H. Gr 19a. Informant's Name/Relations	oomes,	Sr.			18		Sal	(First, Middle,	anto		p Code)
	permit. Pages 1 and 2 should I Department of Health and Meni Importent: If item 27 is market any njury pr-other treumatic once.		Deborah Groo 20a. Method of Disposition 1 □ Burial 2 □ Cremation	mes (Da	20b. P	93]		side	e P1	ace	, Wald	dorf,	MD	20601 own, State
Baltimore,	permit. Pa Department Importent any njury		21. Smature of Europ Service	License e	out	eu 22	2. Name and 4 46 N.	Was	of Facility	SNO St.	WDEN F	UNEF	odbine RAL HO Le, MD	ME, P.A. 20850
760,	In principle of the pri	ilcai Examiner	23a. Part1. Enter the disease, or shock, or hear failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	caused the death each line. (or as a conseq (or as a conseq (or as a conseq (or as a conseq	uence of):	1	,			THE THIO		-	Approximate Interval Between Onset and Death
.O. Box 68	Physicien: The law requires that the death certificat this certificate has been signed by the attending phy rail director, page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregna birth 2 Feta nant at time of d nown	Ideath 3□	Ectopic pregi					230	d. Date of deliv Month	rery Day Year
٥.	requires that the sear signed by nould be detact		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying caus	se given	in Part I.		101	/es 2□	No 3□Pro	
Vital Records,	en: The law tificate has b tor, page 2 sl	e Completed	25. Was case referred to medica	ı				2	6. Place	of Death	24a. Was autop perfo 1 Yes	rmed? 2 No	24b. Were autoprior to condeath? 1 Yes	opsy findings available ompletion of cause of
Division of Vi	ling After fune	ation; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pendir 2 Accident investi	28a. Date (Mor gation	Inpatient 2 of Injury oth, Day Year)	ER/Outpatier 28b. Time of Injury		Other: Injury at Work? 1 Yes		2	ne 5 ☐ Resid 8d. Describe h		□Other (Speci occurred	fy)
Divis	• Hospitel or Attend 24 hours after death • Funerel Director: etely filled in by the 1	al Certification;	3 Suicide 4 Homicide 29a. Certifier 1 Certifyin	singer 288. Place	e of Injury - At he ding, etc. (Specify e best of my kno	y)			date and		City or Tov	vn, State)		al Route Number,
	To the Hos within 24 h To the Fur completely	Medical		Examiner: On the and man			vestigation, in		ion, deat		ed at the time,	date and pl		to the cause(s)
r	4		30. Name and address of person	who completed cat	se of death (Iten	n 23a) (Type.	Print) K	ENI	NE	D) t	GET 29	Jan 1, 141	14	2004
	Sta Registi		31. Date filed (Month, Day, Year)		Registrar's Signa	ature &	Spa	Ks	/	- (•

		•	For State Registrar	State of	Marylan	-	artmen rtificat			and M	ental Hyg	giene Reg. No.	2004	021	. 76
	Physici	an	Decedent's Name (First, Middle, Last Linda Mae Gump	st)							2. Date of Dea Month January		2004 ^{Yeer}	3. Time of D 9:30A.	
>	/Medio Examin		4a. Fecility Name (If not institution, give		ber)				Location o	f Death		4c. (County of Deat	h	
			Laurel Regional H 5. Social Security Number 6. S		. Age (In yrs.	last birthday)	Lau If Under		If Under 2	24 Hrs.	8. Date of Birt		ince G	Eorge's	Foreign
П	Funeral Director		577–54–3393	□M 2XF		62 Yrs.	Months	Days	Hours	Min.	8. Date of Birt Month, Day July21	, 1941	Wasi	nington,	
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's		y, Town or Lo								10d. Inside City 1 ☐ Yes	
	or 28a-	Directo	10e. Street and Number 4709 Olympia Ave				10f. Zip	Code 20705				-	zen of What Co		
	eath w	Funerai	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13.	Was Dece	dent of Hi	spanic Orio	gin? (Spe	ecify Yes or No-		nited St		
920	ilied within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23s or 28s-f show you'll the Medical Examine must be notified at	þ	1 □ Never Married 2 □ Married 3 【 Widowed 4 □ Divorced	Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	X No		lf Yes, spe 1 ☐ Yes		n, Mexican Specify:	, Puerto	Rićan, etc.)		Black, White Specify:	White	
5-0036	72 ho "natur	eted	15. Decedent's Ed (Specify only highest gra	ducation ide completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa	ation du <i>ring most</i>	of work	ng	16b. Kin	nd of Business/	Industry	
2121	within piene. r then the Me	Completed	Elementary/Secondary (0,12)	College (1-	4or 5+)	Accou						Darc	ars Toy	ota	
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural; or Items 23s or 28s-1 show any njury or other traumatic event, the Medical Examiner mast be notified at ODGs.	To Be C	17. Father's Name (First, Middle, Last, Harry Alfred B	oswell					18. Mothe Rach		(First, Middle, Ellswor				
lary	2 should and he lis main		19a. Informant's Name/Relationship (I Route Numbe	-			
	Health tem 27 other t		Rae Lee DeGuzman 20a. Method of Disposition		20b. F	Place of Disponentery, crei	sition (Nar	ne of	I		ltsvill		cation - City or		
E C	Pages nent of l ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		tate	yland Na	ationa	l Mem.	Park 1				el, Mar	-	
Baltimore,	permit. Departinimports any nju		21. Signature of Funeral Service Licer	13 -=	ward	44	400 P	owae.	L 1417 T	T Ka	Funera Belts	VI I I	me, P.A e. Marv	land 20	705
	- a)		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that ca one cause on ea	used the deat ch line.	th. Do not en	ter the mod	te of dyin	g, such as	cardiac o	or respiratory ar	rest,	1	Approximate Interval Betw Onset and De	reen
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	_ d.	Respi:	ratory	Fail	ure							
B	Examiner		Sequentially list conditions.	b. Proba	ble Se	psis								2 days	
	ate be executed obysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consec										
68760,	ficate be e physician s the buria	edical E	(d											
.O. Box (The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		th 2 ☐ Feta int at time of c	aldeath 3	⊒Ectopic p ⊒ Other (sµ					2	23d. Date of deli Month	,	ear
<u>α</u>	ires that the signed by	by	Part II. Other significant conditions of Morbid Obesity; I	_		-		-				obacco us		the cause of de	
Records,	w requir been si should	letec	Coronary Artery I	Di soaso							24a. Was			topsy findings a	
		Completed	Colonary Artery	JI SCUSC							autor perfo 1 ☐ Yes	isy rmed? 2∕2∏ No	death?	completion of cal 2 No	use of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1500		Oth	or		(Check only o				
of	g Phys er this eral di	n; To	1 Yes 2X No 27. Manner of Death	28a. Date of		ER/Outpatie 28b. Time o Injury		28c. Injun Worl	4 L Nu	-	me 5 Resid 28d. Describe h			oity)	
Division	r Attending Physician: er death. rector: After this certific by the funeral director,	Certification;	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	n 28e. Place		ome, farm, st	М	1 🗆	Yes 2 🔲	No	28f. Location (S City or Tov			ıral Route Numb	oer,
۵	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai Ceri		hysician: To the	best of my kno	owledge, deat					and due to the	cause(s)	and manner as		
	thin 24 thin 24 the F mplete	Medi	one) 29b. Signature and title of continer	and mann				c. License					e signed (Monti		
)				C \$11.	325	201	7	D254					uary 8,	•	
1			30. Name and address of person who Robert Maggin, M.	D 1395	of death (Ite	m 23a) (Type,	Print)		7		1	00075			
**	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature 4		oak		Mary	riand 20	1/07			

			1 - For State Registrar	State of M	aryland / De	partmer ertificat			and M	lental Hy	/giené Reg. No	na s	02477
		٠	Decedent's Name (First, Middle, Las	t)						2. Date of D		. V	3. Time of Death
	Physici		PATRICIA ANN	GOETZ						JAN	21	7 Year 2004	
9	/Medio Examir		4a. Fecility Name (If not institution, give			4b. City	Town, or	Location o	f Death		4c.	County of De	ath
	LXIIII		110 S. Broadw	av		Fr	ostb	urg				Allega	ny
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last birtho		r 1 Year	If Under 2	24 Hrs. Min.	8. Date of Bi	rth av. Year)	9. B	irthplace (State or Foreign Country)
Г	Director		218 30 0133	M 2 □ X F	71 Yrs	·	Days	riodis	14141.	NOV 8	1932	MAR MAR	YLÁND
	p ,		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location							10d. Inside City Limits
	anyla ahov	5											1 Yes 2 □ No
	28a-1	Director	MARYLAND ALLEGANY 10e, Street and Number		FROSTBU		p Code				10g Cit	izen of What 0	Country?
	a or	급	110 S. BROADWAY			101. 21	215	32				U.S.	
	eath	by Funerai	110 5. BROADWAT	12. Was Decedent	Ever in U.S.	3. Was Dece			gin? (Spe	ecify Yes or N Rican, etc.)	0-		nerican Indian,
	iter d	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣					, Puerto	Rican, etc.)		Black, Wh	nite, etc.
98	urs a	b	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:				Specify:	WHITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 ahow he Medical Exercitive coast be recitified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. D	cedent's Usu	al Occupa	ation during most	of worki	ina	16b. K	ind of Busines	s/Industry
21	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT L	ise retired	()			_		
	ygier ygier yer th	So	12		S	ECRETA	RY	40 14-15-	de Nove	e (First, Middle		INSURAN	CE
pu	be fill d off	Be	17. Father's Name (First, Middle, Last)							L YOUN			
yla	12 should be filed within hand Mental Hygiene. 7 is marked other than "Iraumatic event, the Men	2	JOHN HARTIG 19a. Informant's Name/Relationship (7)	Supp. Grintl	10h M	niling Address	o /Stroot /					r Town, State,	Zin Codo)
Maryland	d 2 st th and 7 is r traur		JOHN GOETZ / SON	ype, rnin)		-		*		*		, LA 7	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23a or 28a-1 show other traumatic event, the Medical Exprisive Lives for netiting at		20a. Method of Disposition		20b. Place of D	sposition (Na	me of	-	1/22		-	cation - City o	
Baltimore,	Pages nent of h int: If ite iry or of		1 Burial 2 Cremation 3 4 Donetion 5 Other (Specify		THE CUM	crematory or			-	/04	CID	1BERLAN	ID MD
ij	artme		21. Signaturenot Funeral Service (icen		IRE CUP	22. Name a							STREET
Ba	permit. Pages 1 and 2 a Department of Health ar important: If Item 27 is any injury or other trau		Y Mairloux	no	wess	SOWERS	FUN	ERAL	HOME	. P.A.			MD 21532
Н			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do not								Approximate Interval Between
	Physician		Immediate Cause (Final	A* .	,		Lun						Onset and Death
	/Medical		disease or condition resulting in death)	a	a consequence of)	06		<u> </u>		·			17 YEARS
0	Examiner		Sequentially list conditions	b									
	- E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of).								
1	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
g	ate be executed thysicien and the burial-transit	E		Due to (or as	a consequence of):								
876	the by	dical		d									
9 X	law requires that the death certifics as been signed by the attending pt 2 should be detached for use as t	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							23d. Date of de	elivery
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 ☐ Fetal death t time of death	3 ☐ Ectopic p 5 ☐ Other (s						Month	Day Year
o.	the d by the achec	Jysi	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9□ Unknown									
σ,	ires that the death cer signed by the attendin d be detached for use	by PI	Part II. Other significant conditions of	ontributing to death b	out not resulting in th	e underlying	cause give	en in Part I.		23e. Did	tobacco u	ise contribute	to the cause of death?
rds	w require been sig should b	ed b								1)20	Yes 2	□No 3□F	Probably 4 Unknown
000	aw requis been 2 should	piet								24a. Was		24b. Were a	autopsy findings available completion of cause of
of Vital Records,	The lav	Completed	,							perf	ormed?	death?	s 2 No
ita		Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only	one)		
<u>></u>	Physician: this certificant	2	1 Yes 2 No	Hospital: 1 Inpatio				4 🗆 Nui				6 □Other (Sp	ecify)
n o	Ing P	0	27. Manner of Death Salaria 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Tim ly Year) Inju		28c. Injun World			28d. Describe	how injur	y occurred	
sio	Attending or death.	cati	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 □ I		Opt I anating	(Canada a a	of Alcombines and	3 1 0 1 1 1 1
Division	I or Attending after death. Director: After in by the funer	Certification:	4 Homicide determined	286. Place of In	ury - At home, farm c. (Specity)	street, factor	у, опісе				wn, State		Rural Route Number,
_	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	al Ce	29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge, o	eath occurred	at the tim	ne, date and	d place,	and due to the	cause(s)	and manner a	as stated.
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner st	f examination and/o	rinvestigation	n, in my of	pinion, deat	th occurr	ed at the time	, date and	I place, and du	ue to the cause(s)
	To the within To the comple	×	29b. Signature and title of certifier	2 //		29	c. License	e number			29d. Dat	e signed (Mor	nth, Day, Year)
	^		I non C.	dullu	~	1)421	720	m	0	01/	22/200	Y
	1/2		30 Name and address of person who	completed cause of	death (Item 23a) (Ty			- , ,		^		ì	1 4 -1
_	7 0		Gre66 C.	Donak	1500	413		seto		DI,	(mbe	rland mo
		ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	1.	P 27 -						
	Regist	(all	JAN 3 0	LUUT	was S.	6234	1						

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium

Division of Vital Records, P.O. Box 68760,

	For		State	of Ma	aryland /						lental I	Нуді	ene 🤈
	1 - State Registrar AME	ND#24ape	MD1/16/04	, HMW,	,MbCo	Cer	titicat	e of	Death			Re	g. No.
in al	1. Decedent's Name	e (First, Middle,		Gos	lee Hea	aley					2. Date o Month Janua		Day
er	4a. Facility Name (I	f not institution,	give street and nu	ımber)			4b. City,	Town, o	r Location	of Death			4c. Cou
	4205 Eas	t West	Highway				Ch	ievy	Chas	e			Mo
	5. Social Security N 268-36-45		5.Sex 1 □ M 2 🔯 F	7. Ag	e (In yrs. last t	virthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month) May	Birth Day 20,	Year) 1942
	Usual Residence of	Decedent											
	10a. State	10b. County			10c. City, To	wn or Lo	cation						
ctor	Maryland	Montgo	mery			Che	vy Ch	ase					
ě	10e. Street and Nur	nber					10f. Zip	Code				10	g. Citizen
a D	4205 Eas	t West	Highway					20	0815			Ţ	Jnite
Funeral Director	11. Marital Status		12. Was Dec Armed F	orces?		13. \	Vas Dece	dent of H	lispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes o Rican, etc.	r No-	14. F
by Fu	1 Never Marri		d 1 □Yes If Yes, G Year or [ive	No		I □ Yes	2 K No	Specify	:			Spe

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

College (1-4or 5+)

			2. Date of D	eath	D	Mariana	3. Time of	Death
Healey			Januar	У	9, 200	Year)4	7:24	Α ^M
	4b. City, Town, o	r Location of Death			4c. County	of Death	1	
	Chevy	Chase			Mont	tgome	ery	
last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D May 20	av. Y	1942	Col	nplace (State o untry) nsylvan	
ty, Town or Lo	ocation						10d. Inside Cit	y Limits
Che	vy Chase						1 ⊠ Yes	2□No
	10f. Zip Code			10g	. Citizen of	What Co	untry?	
	20	0815		U	nited	Stat	es	
J.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-		ce - Amer ck, White	ncan Indian, , etc.	
	1 ☐ Yes 2🛱 No	Specify:			Specif	w: Wh	ite	
(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16	b. Kind of B	usiness/l	ndustry	
Br	oker]	Real H	Estat	e	
		18. Mother's Name	e (First, Middle	e. Ma	iden Sumar	ne)		
		Elsie H	Evans					

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2004

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 7557 Wisconsin Ave., Bethesda, MD 2

4205 East West Highway, Chevy Chase, Maryland 20815 January 10,

Physician /Medical

Physician

Funeral

Director

ehow

ms 23a or 28e-f ehor

the Mudical Examiner ŏ

Be

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deeth with the Maryland

Baltimore, Maryland 21215-0036

/Medica Examine

> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print) Robert J. Healey/Husband

* 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

James Goslee

20a. Method of Disposition

100				1001	MISCOURT	\mathbf{n} \mathbf{A}	bechesua,
23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplication	ons that caused the dea	th. Do n	ot enter	the mode of dying,	such as cardia	c or respiratory arrest,
Immediate Cause (Final disease or condition	а	Myocardial	. Inf	arc	tion		
resulting in death)		Due to (or as a conse	quence o	f):			
		Arteriosc1	eros	is			

M00198

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FFMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

à

Completed

Be

٩

Certification:

icai

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

20c. Location - City or Town, State

Bethesda, Maryland

/ Chase 20814-3501

Bethesda-Chevy

Inc.

Approximate Interval Between Onset and Death

Year 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 XYes 2 ☐ No 27. Manner of Death

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

2 ☑ No

24a Wasan

1 ☐ Yes

26. Place of Death (Check only one)

29a. Certifier (Check only one)

1 XNatural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D0001601

January 9, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5454 Wisconsin Ave., #675, Chevy Chase, Maryland 20815 Frank C. Blackburn, M.D.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year) JAN 1 6 2004

5 Pending

investigation

determined

6 ☐ Could not be

32. Registrar's Signature

24 hours a

within 2

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 12, January 2004 7:45 A Vodrey Frank Hendricks /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Jan. 5, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpface (State or Foreign **Funeral** 1**X** M 2□ F Washington, DC 80 577-12-5716 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1X Yes 2 □ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 8201 16th Street, Apt. #1018 20910 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces?

120 Yes 2 No 194

ff Yes, Give Year or Dates: 194 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1943be filed within 72 hours after 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 1946 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Efementary/Secondary (0-12) Electronic Technician Federal Government permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier important: If Item 27 is marked other than yinjurg or other treumatic event, III QUER. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Hendricks Aline Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) 8201 16th St. #1018, Silver Spring, MD Nannie H. Hendricks Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/19/04 Lincoln Memorial Suitland, MD 4 □ Donation 5 □ Other (Specify) 21. Signate of Funeral Service Licenses 22. Name and Address of FacilityMcGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20012 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Respiratory failure /Medical Due to (or as e consequence of) Examiner Bilateral pneunomia Sequentially fist conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed Severe dehydration use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Gastro Intestinal Bleed IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No. detached 9 ☐ Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, been signe should be o 1 ☐ Yes 2 🌠 No 3 ☐ Probably 4 ☐ Unknown Cerebro vascular accident Non insulin dependent and diabetes mellitus 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed? Yes 2 No Hypertension 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Pface of Death (Check only one) Hospital: 1 Alnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 FR/Outpatient 3□ DOA funeral 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending s after de-2 🗆 No 1 Tyes 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 669 3 DY. Usn 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 12107 Heritage Park Circle, Silver Spring, MD Ghousia Sultana, M.D. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JAN 15 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** <u>5:5</u>0 A.[™] January 8, 2004 Henry Regis Herbert /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Hospice Casey House Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 15, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□**y**M 2□F Pennsylvania 69 Director 203-24-6672 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Potomac Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23s or United States 10304 Democracy Lane 20854 death Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No 1960-14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical and once. Black White etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1963 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medicine Physician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henry Regan Herbert Katherine Helring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10304 Democracy Lane, Potomac, Maryland 20854 Susan M. Herbert/Wife 20b. Place of Disposition (Name of commetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition January 9, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M01353 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Prostate Cancer Year **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year detached for 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 KOther (Specify)Hospice 1 ☐ Yes 2 ☑ No ို 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this filled in by the funeral d this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO041218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, M.D., 6001 Muncaster Mill RD., Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 12 2004 sacker Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** РМ 2:35 January 14, 2004 Lynn G. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Adelphi Hillhaven Nursing Center Inc. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1⊠M 2□F January 4,1922 Washington, DC 82 579-38-1330 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28e-f show amounts or other traumatic event. The Modical Extrainer main be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 📉 No Director Burtonsville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20866 3017 Greencastle Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 A No Specify: Baltimore, Maryland 21215-0036 à 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Electronics Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lillian May Gronna Joseph Aloysius Herbert Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Celeste P. Herbert/ Wife 3017 Greencastle Road, Burtonsville, MD 20866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 15 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Metropolitan Creamtory Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 inchen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia 2 weeks Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 XUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo ဥ After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only anel To the 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and D31563 January 15, 2004 +1 35 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 Lockwood Drive, #205, Silver Spring, MD 20901 Charles Benner M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 5 2004 Registrar

			For State Registrar	State of Maryland / Dep Ce	artment of Health and M rtificate of Death	Mental Hygie Reg.		02482
	Physici	an	1. Decedent's Name (First, Middle, Last,			2. Date of Death Month Jan	Day 11, 2004	3. Time of Death 4:45 P M
	/Medic	al	DEL] 4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	1.13
	Examin	er		dolph Rd,	Silver Spring		Montgor	
	Funeral Director		5. Social Security Number 6. Security Number 213-24-3528	7. Age (In yrs. last birthday) M 2 XF 81 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Aug. 6, 1	9. Birtho 922 Was	place (State or Foreign htry) h. DC
(0	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Examinating be notified at	Funeral Director	Usual Residence of Decedent 10a. State	Lph Road 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □Yes 2♥0 No	er Spring 10f. Zip Code 20904 Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto		Citizen of What Cour U.S.A. 14. Race - Americ Black, White,	ean Indian, etc.
21215-0036	within 72 hours a ene. than "natural", o	ompleted by	3₺ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 8 th	e completed) (Givi	adent's Usual Occupation be kind of work done during most of work DO NOT use retired) HOUSEWIFE		Specify: Bl. b. Kind of Business/Ind Home	
and 2	d be filed ental Hygi ced other c event, I	o Be Co	17. Father's Name (First, Middle, Last) William Adam	s	18. Mother's Nam	ne (First, Middle, Ma. Orence	iden Sumame)	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant he notified at once.	T	19a. Informant's Name/Relationship (7) Florence V. T 20a. Method of Disposition **Osurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Sunature Funeral Service Licens	alley (Daughter) Removal from State Removal from State Removal from State		olph Rd. Date 20 6/04 O OWDEN FU	, Silver c. Location - City or To lney, MD NERAL HO	Spring, own, State
8760,	hysician and physician and physician and physician and physician and physician are the physician and physician are the physician and physician are the physi	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ications that caused the death. Do not energy cause on each line. a. Diabetes Mel Due to (or as a consequence of): b. Cardiomyopat Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	litus	or respiratory arrest		Approximate Interval Between Onset and Death
P.O. Box 6	death certi e attending od for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of delive Month	ery Day Year
	w requires that the sbeen signed by the should be detache	þ	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	
of Vital Records,	The law ate has b	Completed				24a. Was an autopsy performe	d? prior to co death?	psy findings available mpletion of cause of 2 No
Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)	- 0 Flores (C)	
Division of	or Attending fler death. Jirector: After in by the fune	Certification; To	1 Yes 2 No 27. Manner of Death Matural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, s building, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	et and Number or Rura	
_	e Hospital 24 hours a e Funeral D etely filled	edical Ce	29a. Certifier	sician: To the best of my knowledge, dea iner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
•	To the To the Complete	Me	29b. Signature and title of certifier 30. Name and address of person who	TYQ mpleted cause of death (Item 23a) (Type	29c. License number D36980 p. Print)		. Date signed <i>(Month,</i> Jan. 13	, 2004
	St Regist	ate rar	S.K. Angra, M. 31. Date filed (Month, Day, Year) JAN 14 20	I.D. 344 Univers	sity Blvd., #11	3, Silve	er Spring	, MD 2090

			For State Registrar	State of Ma	arylan	•	artment rtificate			and M		iene	2001	026	.00
			1. Decedent's Name (First, Middle, Las)							2. Date of Death	h Day	Year	3. Time of D	eath
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}	Examin		4a. Facility Name (If not institution, give				4b. City, T	_		f Death			ounty of Death		
			Manor Care Beth		- (la una l	land birthdaul	Bet If Under 1	heso	1a If Under 2	24 Hrs	9. Date of Birth	Mo	ntgomer		Comina
11	Funeral Director		5. Social Security Number 6. Se 890–62–4340	7 44 GRY F	e (in yrs. i 00	last birthday) Yrs.		Days	Hours	Min.	8. Date of Birth (Month Day, May 30,	Year) 0:	3 Gern	place (State or F Intry) IANY	-oreign
			Usual Residence of Decedent												
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	Sa-f	cto	Maryland Montgomer	У	Ве	ethesd								1 🗆 Yes 2	- KI NO
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	s 23s	ral	6530 Democracy B1	Vd •	Ever in III	e 12 l		0817	nania Oria	nin? /Sno	cify Yes or No-		ted Sta		
	Iten de	Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces?		3. 13.1	f Yes, specif	fy Cuban	, Mexican	, Puerto I	Rican, etc.)		Black, White	etc.	
920	urs af	by	3 ⊠Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	⊠ No	Specify:			S	Specify: Wh:	Lte	
21215-0036	72 hours after death with the Marylend natural', or Items 23s or 28s-f show disal Examerist must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed)		16a. Deced	ient's Usual kind of work DO NOT use	Occupat done du	tion uring most	of working	70	6b. Kind	d of Business/I	ndustry	
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2	lied w tygiei ther ti		17. Father's Name (First, Middle, Last)	1		пошеша	akei		18 Mothe	r's Name	(First, Middle, N				
and	d be fantal h	o Be	Wilhelm Marx						Soph		Oppenh				
Maryland	Should Me Me mark	T	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	ng Address (Street a	nd Numbe	r or Rura	l Route Number,	City or	Town, State, Zi	o Code)	
Ž	aith ai 27 is ar trau		Albert A. Hirsch	(Son)		7208	Delaf	field	d Str	eet,	Chevy (Chas	e, MD	20815	
ore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 1	Romoval from State	C	lace of Dispo emetery, cren	natory or oth	her place)				ation - City or T		
Ĕ	Page ment		'4 □Donation 5 □ Other (Specify,		Che	sapeak	ce Cre	matc	ry Ja	an. l	.3 ,2004 B	elts	sville,	MD	
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylam Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show ampointment or Other traumatic event, Itis Madical Experiment making nutified at once.		21. Signature of Funeral Service Licens	0	261	R:	Name and app Fu	Address inera	of Facility al An	d Cr	emation ver Spri	Ser	vice MD 20	910	
	nerolii.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death	n. Do not enti	er the mode	of dying	, such as	cardiac o	r respiratory arre	st,		Approximate Interval Betwe	en.
	Physician		Immediate Cause (Final disease or condition	Doc	DIV	n to	11	6	α	Our	VP			Onset and De	
	/Medical		resulting in death)	a. Due to (or as	a consequ	uence.of):			7		A				
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	pe tis	ine	grantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):	9								
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Вох	leath certifica attending ph I for use es th	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pre	onancy				23	d. Date of deliv	•	
	0 80	sicle	in the past 12 months?	4 Pregnant at			Other (spe						Month	Day Yea	ar
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JS,	es be	by	Part II. Other significant conditions co	ntributing to death b	ut not rest	aking in the ur	idenying car	ase giver	ı in Fan I.		1 🗆 Ye	-	No 3 □ Pro		
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of	g Phys er this eral di		27. Manner of De th	28a. Date of Inju	ry	28b. Time of Injury		c. Injury Work	at		8d. Describe how			,,	====
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Division	l or Atten after daat Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc.			eet, factory,	office		2	8f. Location (Str. City or Town,		Number or Rur	al Route Numbe	r,
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	e Hospital 24 hours a e Funerel l letely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of iner: On the basis of and manner sta	f examinat	wiedge, death tion and/or inv	estigation, i	t the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the car id at the time, da	use(s) ar te and p	nd manner as s lace, and due t	stated. o the cause(s)	
	To the Hospital or Attent within 24 hours after daalt To the Funerel Director: completely filled in by the	Med	29b. Signature and title of certifier	and mainer of			29c.	License	number		29	d. Date :	signed (Month,	Day, Year)	
-	V		Marlina	(lone	un	MIL	D	35	79	1		1/8	104		
	,		30. Name and address of person who o	ompleted cause of d	leath (Item	23a) (Type,	Print) N	TERI	y MY	EMU	Ry, m. 5	7	110	2000	7.2
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	Physici	20	1. Decedent's Name (First, Middle, Las	t)	HOUTO					Date of Dea Month		Year	3. Time of Death
	Physici /Medio		Anne		HONIG					January	y 12,	2004	5:50 A M
	Examir	er	4e. Fecility Name (If not institution, give Suburban Hospit		9r)			Location of	Death			nty of Deeth	
		2-	5. Social Security Number 6. S		Age (In yrs. last birtho		etheso	I a If Under 24	4 Hrs. g	Date of Birth		gomery	
	Funeral Director			□ M 2 💢 F	97 Yrs	Month	Days	Hours	Min.	Date of Birth (Month, Day Ctober	Year)	O6 Pol	plece (State or Foreign htry)
	D		Usual Residence of Decedent							LODEL	10,17	1476	
	anylar show	_	MD Montgome	rv	10c. City, Town o	r Location ckv i 1 1	Δ					1	0d. Inside City Limits 11 Yes 2 □ No
	the M	ecto	10e. Street and Number	- /			ip Code				log. Citizen o	4146-4-0	
	with Se or	Funeral Director	6105 Montros	e Road			0852				-		.uy r
	death	era	11. Marital Status	12. Was Decede		3. Was Dec	edent of His	spanic Origi	in? (Specif	y Yes or No-	14. R	S.A. ace - Americ	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23e or 28e-1 show imatic event, the Medical Examinar must be notified as	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Force 1 ☐ Yes 2 [If Yes, Give Year or Date	XNo		ecify Cubar 2 No	Specify:	Puerto Ric	an, etc.)	Spec	lack, White,	_{etc.} 'hite
Š S	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. De	cedent's Us	ual Occupa	tion	of working		16b. Kind of	Business/Ind	dustry
2	Atthin han	nple.	Elementary/Secondary (0-12)	College (1-4d	or 5+)	ive kind of ve. DO NOT		0g	or working				
2	filed withi Hygiene. other ther	S	1 Z 17. Father's Name (First, Middle, Last)		Ho	nemake		10 Mothod	a Nama /f	irst, Middle, I		Home	
and	ould be filed v I Mental Hygie Parked other t hatic event, th	o Be		szcyk					ara	rist, Middle, i	Maiden Sum	ame)	
2	shoul nd Me mark	F	19a. Informant's Name/Relationship (1		19b. M	ailing Addre	ss (Street a			oute Number	r, City or Tow	m, State, Zip	Code)
Š	alth a		Sonia Danshes /	laughter						Sprin			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked to any injury or other traumatic events.		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		te 20b. Place of Di cemetery, Ohev Sho	crematory of	other place		Date h 1/1		20c. Location		
	mit. F partm porter / injui		21. Signature of Funery Fervice Licen			22. Name	and Address	s of Facility		neral	wasni	-	, DC
m	8818		Weber Story	1		254	insky arrol	nebro	ew ru N.W.	neraı Washin	Home,	Inc. DC 20	012
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caus	ed the death. Do not line.	enter the m	de of dying	, such as ca	ardiac or re	spiratory arre	est,		interval between
	Physician		Immediate Cause (Final disease or condition	a	NEUMO	NIA							Onset and Death
п	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):								
Н		0	Sequentially list conditions, if any, leading to immediate	b. Due to ror	BEHY DR	ATTO	N						
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ó	exec en an rial-tr	Exa	resulting in death) Last	Due to (or a	as a consequence of):								
8760,	rcate be executed physicien and the burial-transit	dical		d									
9	ing ph e as t	Med	IF FEMALE:			-						1	
Box	death certifi e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic						ate of delive	ry Day Year
o.	0 0 2	yslo	1 □ Yes 2 No 9 □ Unknown	9☐ Unknown		5 Other (іресіту)						•
ص ِ	The law requires that the to be a signed by the bas been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions of	ntributing to death	but not resulting in th	e underlying	cause give	n in Part I.		23e. Did tob	oacco use co	ntribute to th	e cause of death?
rds	requires been sign should be									1 □ Y∈	s 2 No	3 🗀 Proba	abiy 4 🗆 Unknown
Records,	s bee	Completed							Ī	24a. Wasa		. Were autop	osy findings available
	Physicien: The lav this certificate has al director, page 2	mo;								autops perform 1 Yes 2	ned?	death?	npletion of cause of
Vital	sien: artifica	Bec	25. Was case referred to medical examiner?					26. Place o	f Death (C	heck only on		, ,	23.10
5	Physic this carral dire	은	1 □ Yes 2/1 No	Hospital: 1 Inpa			100	4 Nurs		5 🗆 Reside)
חכ	Viter uner	lon	27. Manner of Feath Nature 5 □ Pending		njury 28b. Time Day Yeer) Injur	У	28c. Injury Work	? _		. Describe ho	w injury occu	urred	
Division of	il or Attending Physicien: after death. Director: After this certific In by the funeral director.	ficat	Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury - At home, farm,	M street facto		es 2□No		Location (St	reet and Nun	ther or Rural	Route Number.
2	after after Dire	Certification:	4 Homicide determined	building,	etc. (Specify)	Siroot, radio	, 011100		2011	City or Town		,007 07 110707	riodie redinber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	edical C	29a. Certifier (Check only one) Certifying Ph-	iner: On the basis	st of my knowledge, de	ath occurre investigation	d at the time	e, date and p	place, and occurred a	due to the ca	ause(s) and n	nanner as sta	ated. the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	and manner	stated.		c. License				9d. Date sign		
		NU.	1 Almarel	men	j M.	_	7		766	_	///	2/0	4
	3		30. Name and address of person who	ompleted cause of	f death (Item 23a) (Typ			~			-/-	-1/	
			010 6 00/01	ani M	D. 11110		CKW	UE	PIK.	z K	CKU	ius.	MD2850
	Sta	-	31. Date filed (Month, Day, Year)		strar's Signature	1	no W.	/		/			
	Registr	ar	TEN 1 4 20	101 /	M	1310	COLOROLI						

			1 - For State Registrar	State of I	Marylaı		artmen <i>rtificat</i>				lental Hyg	giene Reg. No	1 4 2	04	02	485
	Dhusisi		1. Decedent's Name (First, Middle, La	ast)							2. Date of Dea Month	ath Da	ev.	Year	3. Time	of Death
	Physici /Medic		Helen Morri	n Hahn							January	_	•		2:45	5 P M
3	Examir		4a. Fecility Name (If not institution, gire	e street and numb	er)		4b. City,	Town, or	Location of	of Death		40	. County	of Death		
			Holy Cross Hosp						Spr				lontg			
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, <i>Year</i>))	9. Birth	place (State intry)	e or Foreign
	Director		377-22-9840		76	Yrs.					June 26	, 1	927	Wis	consi	n
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							T	10d. Inside	City Limits
	danyi f sho	ō				T T1										s 2⊠No
	the 1	Director	Maryland Montgom	ery		Whea	10f, Zip	Code				10a. Cit	tizen of W	/hat Cou	intry?	
	Sa or		11106 N1 D										US		,	
	be filed within 72 hours after death with the Maryland lal Hygiene. d other than "naturel", or Items 23e or 28e-f show event, tre Medical Exertiner must be recitied at	Funeral	11106 Norlee Dr	12. Was Decede		J.S. 13.	Was Deced	209 tent of Hi		gin? (Sp	ecify Yes or No- Rican, etc.)	.	14. Race	- Ameri	can Indian,	
ယ	after or ite	Ē	1 ☐ Never Married 2 X Married	Armed Force							Rican, etc.)			k, White		
හි	ei', d	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		1□Yes :	2KJ No	Specify:				Specify:	Ameı	cican	India
Baltimore, Maryland 21215-0036	72 hc	Completed	15. Decedent's E			16a. Dece	dent's Usua kind of wor			t of work	ina	16b. K	(ind of Bu	siness/Ir	ndustry	
2	thin and	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired)	O NOTA	g					
2	filed w Hygien other th	Co		4		Re	giste	red					<u>lealt</u>		are	
힏	d oth	Be	17. Father's Name (First, Middle, Last	1)					18. Mothe	r's Name	e (First, Middle,	Maiden	n Surname	9)		
Хļа	should be and Mental marked o	2	Mitchell K								th Tucke					
<u>la</u>	2 sh and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	or or Rura	al Route Numbe	r, City o	or Town, 5	State, Zij	code)	
<u>~</u>	es 1 and 2 should b of Health and Ments fitem 27 is marked r other traumatic		Clifford P. F	lahn/Husba	and				rive		eaton, 1					
0	Pes 1		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from Sta		Place of Dispo cemetery, crer	natory or o	ne of ther plac	e)		Date lary 9	20c. L	ocation - (City or T	own, State	
Ë	permit. Pages 1 Depertment of H Important: If ite any Injury or ot		*4 □Donation 5 □ Other (Speci	<i>fy</i>)	1	tropoli						Ale	xand	ria,	Virg	inia
Za Za	epert poor ny Inj		21. Signature of Funeral Service Life	nsee	1_		2. Name an							- 3		
_	20 E E 9		Gra S.	scere	7	50	0 Uni	vers	ity F	lvd.	Tuneral W.Silv	rer	e in Spri	c. ne.	MD 20	901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	sed the dea n line.	th. Do not ent	er the mod	e of dying	g, sučh as	cardiac	or respiratory are	rest,	-1	0,	Approxim Interval B	etween
	Priysician		Immediate Cause (Final disease or condition	. Metast	atic	Adenoc	arcin	oma							Onset and	
ſ	/Medical		resulting in death)			quence of):	G_ C	Oma							o mon	CIIIO
	Examiner		Sequentially list conditions	b. Non-Sn			ng Ca	ncer							5 yea	rs
	₽ ≒	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conse	quenca of).									-	
	ecute ind trans	аш	Cause (Disease or injury that initiated events resulting in death) Last	c												
Ö,	e exe	ũ	resulting in death) Last	Due to (or	as a conse	quence of):										
8760,	icate be executed physician and s the burial-transit	dlcal		d										-		
9	death certificate be executed e attending physician and nd for use as the burial-transit	Mec	IF FEMALE:											-		
Вох	leath certific attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth			Ectopic pr	egnancy				1	23d. Date Mon		ery Day	Year
O.	he at	sicl	1 ☐ Yes 2 ☐ No	4□ Pregnant 9□ U <i>n</i> known		death 5	Other (spe	ecify)					IVIOII	uı	Day	Teal
<u>~</u>	that the de led by the detached	Ph	9 Unknown					-								
	50.00	þ	Part II. Other significant conditions		n but not re	suiting in the ui	naerlying ca	ause give	in in Part I.		23e. Did to					
ord	w require been si should b	Completed	Cerebrovascular	Accident							1 L Y	es 2	UNO ⋅	3 🔯 Proi	oably 4	JUNKNOWN
ပ္ပ	e law r has be je 2 sh	ple									24a. Was a autop:	SV	24b. W	ere auto	psy finding mpletion of	s available cause of
<u> </u>	Th ate pag	io l									perfor	med? 2⊠ No	de	eath?	2□ No	
ij	icien: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	55					26. Place	of Death	(Check only or	16)				
>	I or Attending Physicien: after death. Director: After this certific I in by the funeral director,	2	1 ☐ Yes 2 🔀 No	Hospital: 1 ☑ Inpa	atient 2	ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 □ Nu	rsing Ho	me 5 Resid	ence	6 □Othe	r (Specil	(y)	
0	neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In	njury Day Year)	28b. Time of Injury	2	Bc. Injury Work	at ?		28d. Describe h	ow injur	ry occurre	d		
Division of Vital Records,	Attending r death. sector: After y the fune	atle	2 Accident investigation	n			М	1 🗆 ነ	/es 2 □ f	No						
Ξ	er de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	Injury - At h	nome, farm, str	eet, factory	, office		1	28f. Location (S City or Tow			r or Rura	al Route Nu	mber,
	ital or rs afte el Dir	Cer														
	Hospital 24 hours a Funerel I tely filled	cal	29a. Certifier 1 ☐ Certifying Pi	nysician: To the be miner: On the basis	st of my kn	owledge, death	occurred a	at the tim	e, date and	d place, a	and due to the c	ause(s)	and man	ner as s	tated.	(e)
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	ledical	one)	and manner	stated.					- COCUIT						(3)
	with To t	Σ	29b. Signature and title of certifier	1			29c.	. License	number		2	9d. Dai	te signed	(Month,	Day, Year)	
	8		find M	Sune	01.	40		D3.	5996			Jar	nuary	9.	2004	
_	V		30, hime and address of person who	leted cause of	of death (Ite	m 23a) (Type,	Print)				-	F 54-521		one de	eserente.	
			Linda M. Burrel				rsity	Blvd	. #90	0, W	heaton,	MD	2090)2		
	Sta		31. Date filed (Month, Day, Year)	32. F a gi	strar's Sign	ature &	100	uks	1							

	\$	State of Maryland / Department of Health and N	Mental Hyg	giene	4-02486	
		Decedent's Name (First, Middle, Last)	2. Date of Dee Month	th Day	3. Time of Death	
	Physician	Sister Frances Hill	Jan. 2			М.
	/Medical Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or L	ocation of Death	4c. County		
		St. Vincent Care Center Emmitsh			lerick	
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs Months Days Hours Min.	(Month, Day	Year)	Birthplace (State or Foreig Country)	חן
	Director	014-40-3109 1 M 2 M F 88 Yrs. Usual Residence of Decedent	Feb. 8	8, 1915	Virginia	
	pue *	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit	s
	Mary 1 sho	MD Frederick Emmitsburg			1⊈ Yes 2□No	٥
	vith the Mar or 28a-1 s be notified Director	10e. Street end Number 10f. Zip Code		10g. Citizen of W	/hat Country?	
	ath with the Marylenc 123e or 28e-f show 11st be notified at 1ral Director	335 South Seton Avenue 21727		U.S.A.		
	r itams 23s	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (St. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-		- American Indian, k, White, etc.	
0	or its	1 Never Married 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify:	,,	Specify		
21215-0020	urai', o	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			White	
5	n 72 h	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Bu	is Community	
212	withi ene. than	Elementary/Secondary (0-12) College (1-4or 5+) College 5+ Teacher and Child Car		_	s of Charity	
P	be filed within 72 hours after death with the Marylend ital hygiene. d other than *natural; or itams 23a or 28a-f show event, the Medical Experiment rougher notified at Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) 18. Mother's Name				
ılar	uid be filed within 72 hou Mental Hygiene. Irked other than "natura titic event, the Medical E To Be Completed	Richard Gregary Hill Eliza	Benson_1	Bilisely	7	
Maryland	shot and N sma	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			State, Zip Code)	
	and 2 saith 27 is er tre	Sister Camilla Harant 333 S. Seton Ave., E			21727	
ore	of He	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location -	City or Town, State	
Ë	Pag iment bant: I	4 Donation 5 Other (Specify) ST. JOSEPH'S P.H. 1/2	29/04	EMMITSBU	JRG, MD 21727	_
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health end Mental Hygimportant: if Item 27 is marked other any injury or other treumatic event, once. To Be C	21. Signature of Funeral Service Licensee 22. Name and Address of Facility S 210 W. MAIN ST., E	KILES FU			
		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between	
4	Physician	, , -			Onset and Death	
	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) a. The immediate Ceuse (Final disease or condition resulting in death)			8413	-
	ă la la	Due to (or as a consequence of):				
(0)	executed in and riel-transit	b. Due to (or as a consequence of).				_
ó	ste be executed sysician and he buriel-transit lical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried quarter.				
1760	ite be iysicia ne bur	Cause (Disease or injury c				
Box 68	or Attending Physicien: The law requires that the death certificet shart death. Director: Atter this certificate has been signed by the attending phy in by the funeral director, page 2 should be deteched for use as the straight of the funeral director, page 2 should be deteched for use as the straight of the funeral director. To Be Completed by Physician/Medi	d d				
9	ath ce ttendi or use					
o.	the a thed they hed they hed they hed they hed they hed they hed they help they have help they help they help they help they help they have help they help they have help they h	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		200	tribute to the cause of deat	
9.	that the deed by the detected	Solzine Disorder	1 🗆 1	res 2 No	3 Probably 4 ☐ Unkno	wn
ds,	signe d be	J.S. C. C. C. C. C. C. C. C. C. C. C. C. C.	24a. Was a	an autopsy	24b. Were autopsy findings	5
Ö	v require		perfor	rmed?	available prior to completion of cause of death?	
Re	The law requirester has been single by should completed		1□ ∨	′es 2⊠No	1 ☐ Yes 2 ☐ No	
<u>ta</u>	sicien: The la certificete ha: irector, page 2 o Be Comi	25. Was cese referred to medical 26. Place of Dea	th (Check only o			
<u> </u>	ysicie Is cert direct	examiner?	ome 5 Resid		or (Specify)	
ō	fing Phys n. After this funeral d	27. Manner of Death 28e. Date of Injury 28b. Time of Injury at Work?	28d. Describe h	ow injury occurr	ed	
Ö	leath. for: Aft the fur	2 Accident investigation M 1 Yes 2 No				
Division of Vital Records, P.O.	tal or Attending P rs efter death. al Director: Atter led in by the funer: Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Numb m, State)	er or Rural Route Number,	
Ω	oftal ours of val Dillod ii			(-)	-nor as stated	
	To the Hospital or Attendi within 24 hours effer death To the Funeral Director: A completely filled in by the f Medical Certificati	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occu and manner stated.	rred at the time,	date and place, a	and due to the cause(s)	
	o tha	29b. Signature and title of certifier 29c. License number	20	29d. Date signed	(Month, Day, Year)	
-	m s m o	Rose to The Dead 201-Douts 51 +440	2/ 5	JANUARY	27, 2004	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2 u	MTE	R 57	
		BONITAT KROMPEL- GORTIERDO TI	turn	CNT	MD 7172!	2
	State	31. Date filed (Month, Day, Year) 32. Registrarie Signature JAN 3 0 2004			/	
	Registrar	OFFICE OF LOCAL DE PROPERTY OF				

		-	1 - For State Registrar	State of Mary	land / [epartme		and M	ental Hyg		-	4 0248
V			1. Decedent's Name (First, Middle, Last)						2. Date of Dea	th		3. Time of Death
	Physici /Medic		Doris Elizabeth Hal	nn					January.	Day 17	Yee 2a	8.4
7	Examir		4a. Facility Name (If not institution, give	street and number)		4b. C	ty, Town, or Location	of Death	Janua		County of De	
100			Union Memorial Hosp	ptial		Ba1	timore.					
	Funeral Director		5. Social Security Number 6. Sex 220-16-0536 Usuel Residence of Decedent	7. Age (In	yrs. last birt		der 1 Year If Unde ns Days Hours	Min.	8. Date of Birth (Month, Day May 3,	Year) 1925	9. B Ma	irthplace (State or Foreign Country) aryland
	land ow		10a. State 10b. County	100	c. City, Towr	or Location						10d. Inside City Limits
	Mary -f sh	tor	Maryland Frederick	F	rederi	ck						1 X Yes 2 No
	r 28a	Directo	10e. Street and Number		rederi		Zip Code		1	0g. Citi:	en of What (Country?
	h with	Die	305 Birmingham Cour	rt		21	701		U	SA		
	deat	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was De	cedent of Hispanic O pecify Cuban, Mexica	rigin? (Spe	cify Yes or No-			nencan Indian,
9	or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2 █ No If Yes, Give			2 X No Specify		rican, etc.)		Black, Wh	ille, etc.
	ural',	d by	3 ☐ Widowed 4 🗓 Divorced	Year or Dates:							Specify: Wh	nite
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show aumatic event, the Medical Eventher must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a.	Decedent's U (Give kind of	sual Occupation work done during mo Fuse retired)	st of workir	ng	16b. Kir	nd of Busines	s/Industry
2	Mithin the n	du	Elementary/Secondary (0-12)	College (1-4or 5+)	sel		use retired)			h am a	m a le a se	
2	filed Hygie other		17. Father's Name (First, Middle, Last)		861		18. Moth	ner's Name	(First, Middle, I		maker	
an	d be antal	Be C	Clarence Earl Kemp						elia Wa		,	
2	should bd Me mark matte	2	19a. Informant's Name/Relationship (Ty)	ne Print)	19b	Mailing Addr	ess (Street and Numb					Zin Code)
<u>8</u>	ith ar 17 is 17 is 1 trau		Holly A. Hahn, daug									
ē,	s 1 and 2 should of Health and Men item 27 is marke other traumatic		20a. Method of Disposition		Ob. Place of	Disposition (/ v, crematory o	Parkway, (C304				21702 or Town, State
Baltimore,	Pages nent of I ant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemeter Mt. 01	, crematory c ivet C	emeterv	1/20/3	2004	Fred	erick.	Maryland
	permit. Pages Department of Important: If it any injury or o	l i	21. Signature of Funeral Selvice License				-					uneral Home
ñ	Ded July Sun Sun Sun Sun Sun Sun Sun Sun Sun Sun		Rugu Ma	Loice 1	หกกจจจ	106 F	ast Churcl	h Str	ney and eet. Fr	Das der	ick M	ипетат ноше ID 21701
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the	death. Do n	ot enter the m	ode of dying, such as	s cardiac or	respiratory arre	est,	ICK T	Approximate Interval Between
100	Physician		Immediate Cause (Final									Onset and Death
	/Medical		disease or condition resulting in death)	Mult. 54616 Due to (or as a coo	nsequence t	gan F	ailure					4 days
4	Examiner		Conventially list conditions b	Peripheral 1	lastular	130060						21 %
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor								3. 243
	and and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last									
760,	ate be executed nysicien and he burial-transit		resulting in death) cast	Due to (or as a cor	nsequence o	f):						
-	physicate to the the the the the the the the the the	dicai	d	•							-	
×	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pr	ngnancy.							
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Records ,	uires signi	d by							1 🗀 Ye	s 2[]No 3∰ F	Probably 4 Unknown
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<u>o</u>	Attanding I ir death. actor: After by the funer	atio	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Morter, Day 198	u) in	jury M	Work? 1 □ Yes 2 □]No				
DIVISION	I or Attand after death Diractor: , I in by the f	tifle	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (St	At home, far	m, street, fact	ory, office	2	8f. Location (Str City or Town	reet and	Number or F	Rural Route Number,
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	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my er: On the basis of examination manner stated.	knowledge, mination and	death occurre for investigati	ed at the time, date aron, in my opinion, dea	nd place, ar ath occurre	nd due to the ca d at the time, da	use(s) a ate and	and manner a place, and du	s stated. e to the cause(s)
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			1/2 9	mp			AT2438946		1.	an va.	-y 17	2004
	n		30. Name and address of person who col	npleted cause of death	(Item 23a) (1~			
	1			University Pa		Baltim	xe mo 2	1218				
	Sta		31. Date filed (Month, Day, Year)	32. Registrate S	ignature		and it					
	Registr	:1	JAN 3 U	LYUT MERCE	2100 0 3	2 % Red						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav George Clarence Husfelt January 2004 0840 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 400 Star Route Road Childs Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 217-16-5686 82 April 23, 1921 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits idical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Cecil Childs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 400 Star Route Road 21916 Funeral United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces? World
1 Myes 2 □ No
1 Myes Give War
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No δ Specify: Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retai] other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H litem 27 is marked ot r other traumatic even Clarence B. Husfelt Ida C. George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Star Route Road, Childs, Maryland 21916 George C. Husfelt/Self 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State January 24, * 4 ☐ Donation 5 ☐ Other (Specify) Leeds Cemetery 2004 Leeds, Maryland 21. Signature of Fineral Service Acense 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Approximate Interval Between Onset and Death itions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MeTASTATIC /Medical Due to (or as a consequence of): Examiner Sausa fally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached t 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27XN0 1 🗌 Yes After thi funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and fittle of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Mam and address of person who completed cause of death (Item 23a) (Type, Print) 204 South oseRT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 40 Registrar

State of Maryland / Department of Health and Mental Hygiene 🔒 🦳 📗 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles Alonzo January 1100A. Issina 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5122 Niagara Place College Park Prince George's 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) Sept. 15, 1928 5. Social Security Number **Funeral** Days 15 M 2□ F 215-26-2379 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ehov amportant: if item 27 is marked other than "natural", or items 23a or 28a-1 ehov amplicate injury of other traumatic event, if a Moulcate amplicate routing to rottling an once. Prince George's College Park 1 XYes 2 No Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20740 United States 5122 Niagara Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 17v7 Yes 2 □ No 17 Yes, Give 1946–1948 Year or Dates: 1946–1948 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: Š White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Elizabeth Froehlich Charles M. Issing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5122 Niagara Place College Park, Maryland 20740 Eileen Issing -wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Gate of Heaven Cemetery 1/12/2004 Silver Spring, Maryland 1 Deurial 2 Cremation 3 Removal from State 1 LXBurial 2 □ Other (Specify) 21. Signature of Funeral S Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Esophageal Cancer 6months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Que to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease; Prostate Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c Certification: To 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Magner of Death Injury Natural 2 Accident 5 Pending after death.

I Director: Aff 1 TYes 2 □ No investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours a To the Funeral C filled To the Hospitel 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D26287 January 8, 2004 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7305 Baltimore Ave., #107 College Park, Maryland 20740 Michael Berard, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 13** Registrar

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			1 - For State Registrar		State of M	larylan		artmen rtificate			and M		giene Reg. No	(. = =	1	02490
	Dhysisi		1. Decedent's Name (Firs	t, Middle, Last))							2. Date of De Month	ath Da	ıv Y	'ear	3. Time of Death
The Real Property lies	Physici /Medic		Henı	ry Ludwe	ell Jones	3						Januar				4:30 a M
A.	Examin		4a. Facility Name (If not in					4b. City,	Town, or	Location o	of Death			. County of		
	*		Carriage H						hesd		0411			Montgo		•
	Funeral		5. Social Security Numbe		x 7.A 50Xn 2□F	ge (In yrs. 76	last birthday) Yrs.	If Under Months	Days	If Under:	Min.	8. Date of Bir (Month, Da Mar. 20	th y, Year,	027		lace (State or Foreign try)
*.	Director		226.28.4969 Usual Residence of Dece	rdent							1	Mar. 20), ⊥	921	Vi	rginia
	land ow			County		10c. Cit	y, Town or Lo	cation		-					1	0d. Inside City Limits
	Marylan f show	ţ	MD M	ontgome	ery	C	Chevy C	hase								1 ☐ Yes XX No
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	3a o	Funeral Director	6514 Weste	rn Aven	nue				2081	5				U.S.A	١.	
	death	Jer	11. Marital Status		12. Was Deceden Armed Forces		.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race -		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It marked other then "natural", or Itemis 23a or 28s-f show other traumatic event, the Marcial Extensive must be notified.	by Fui	1 Never Married 2 3 Widowed 4 D		1XXes 2 If Yes, Give Year or Dates	14849-	•	1 ⊡ Yes 2		Specify:	i, Puerto i	nicari, etc.)		Specify:	white, Wh	ite
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	item 27		20a. Method of Disposition				Place of Dispo semetery, crei	sition (Nan	ne of) i	D	ate T	20c. L	ocation - Ci	ty or To	wn, State
Ë	Pages nent of hant of hant: If its uny or of		12 Burial 2 □ Cre 14 □ Donation 5 □	mation 3 UF Other <i>(Specify)</i>	Removal from State		Linco	ln Ce	mete	ry		4,2004			-	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral	Service Licens	ee Las	/						ph Gaw ie NW W				
·C	*		23a. Part1. Egrer the dis	ease, or compl	ications that cause	ed the deat										Approximate
	Physician		shock, or heart failu Immediate Cause (Final disease or condition	ire. List only of	_	monia									2	Interval Between Onset and Death Weeks
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8760,	cate be executed physicien and the burial-fransit	dicai Examiner			d											
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P.0	d by t	Phy	9 Unknown Part II. Other significant	conditions	atributing to doub	hut get ree	ulting in the u	adach is a a		n in Dort I		220 Did 1	000000	uso sostribu	ito to th	e cause of death?
Vital Records,	sign Sign	by	Parkinson'	s Disea	ISE	DUCTION	uning in the u	nderlying ca	ause give	nin Parti.			Yes 2		Prob	v
000	e law requ has been je 2 shoult	Completed										24a. Was		24b. We	re auto	osy findings available inpletion of cause of
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Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:		Could not be determined	28e. Place of li building, e	njury - At ho etc. (Specif	ome, farm, str	eet, factory	, office		2	8f. Location (City or To	Street ar wn, State	nd Number e)	or Rura	Route Number,
	e Hospit 24 hour: e Funera etely fille	Medical C	29a. Certifier 1X (Check only one)	Certifying Phys Medical Exami	sician: To the bes ner: On the basis and manner s	of examina stated.	owledge, deat tion and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s date an	and mann d place, and	er as st due to	ated. the cause(s)
	Fo th within Fo th	Me	29b. Signature and title of	of certifier				29c	. License	number			29d. Da	ite signed (i	Month,	Эө <i>у, Үөаг)</i>
	10		11	ml		m		D	3557	9			Janu	ary 1	2,	2004
	10		30. Name and address of Susan J. Mi	person who co	ompleted cause of	death (Item	n 23a) (Type, ip Hil	Print) 1 Ter	race	Bet	thesc	la, MD	208	316		
	Sta Registi		31. Date filed (Month, Da	1 3 200	32. Begis	trar's Signa		2	exa							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended_item #19a, 1/21/2004, E.T, WCHD 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) Month Day **Physician** D. KOERNER LORETTA 4b. City, Town, or Location of Death 20 04 4c. County of Deeth /Medical 4:40 am 4e Fecility Name (If not institution, give street end number) Examiner Worcester Berlin Nursing & Rehab Center Berlin If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Hours Months 1□M 2XF 84 163-16-3739 5-3-19 Director Pa. Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours aftar death with the Marylend Depertment of Health end Mantal Hygiena. Important: If Item 27 is marked other than "natural" eny injury or other traumatic excessions. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No DE Sussex Directo Selbyville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 54 Box 144 19975 U.S.A. Rt. by Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Resort Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Brady Catherine Flavelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) P.O. Box 772664 Steamboat Springs. CO 80477 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State Hurlock, MD. 4 ☐ Donation 5 ☐ Other (Specify) 1 - 23Md Veterans Cem. 22. Name and Address of Facility Ullrich Funeral Home Berlin, MD. 21811 plications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Leevs **Examiner** Due to (or as a consequence of) Examiner ettending physician end for use as tha bunal-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) eral Director: After thi filled in by the funerel 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Naturel 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Mospital within 24 hours of To the Funeral Complataly filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date(signed (Month, Pey, Year) 29b. Signature and 28769 who completed cause of death (Item 23a) (Type, Print)

Registrar

State

1000167

31. Dete filed (Month, Day, Year)

32. Registrar's Signature.

ANGEN!

State of Maryland / Department of Health and Mental Hygiene > 1 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 15, Januarv 2004 4:45A Anura Karunaratne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Neme (If not institution, give street and number) Examiner Montgomery Potomac 17 Orchard Way North 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Oays If Under 24 Hrs. 8. Oate of Birth (Month, Day, 9-1-34 9. Birthplace (State or Foreign Country) Sri Lanka **Funeral** Months Hours 1X M 2 ☐ F 69 Director 579-78-2128 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₹ No Director MD Montgomery Potomac 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 17 Orchard Way North 20854 Sri Lanka by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Aiffied Folces: 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Appuhamy Karunaratne Podihamine Alankaralage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Orchard Way North, Potomac, MD 20854 Rani Karunaratne - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crem. 1-18-04 Bladensburg, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi F. H. 11800 New Hampshire Ave. Silver Spring, MD 20904 onnell Cilan 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician Metastatic Lung Carcinoma 4 years resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Orsease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Oate of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pa 1 ☐ Yes 2X No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2⊠ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 \$\mathbb{R}\$ Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient ٤ 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1

Natural 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23308 1-15-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor M. Priego, M. D. 6420 Rockledge Dr. #4100 Bethesda, MD 20817 31. Date filed (Month, Day, Year) JAN 16 2004 32. Registrar's Signature State sacks Registrar

			1 - For State Registrar	State of N	/larylan		artment rtificate			d Me		giene Reg. No.	1001	021	.00
	Dhusisi		1. Decedent's Name (First, Middle,	Last)						1	Date of Dea Month	Day	Year		
	Physici: /Medic		Bok Hee Kim				,				Januar		2004		P ^M
	Examin	er	4a. Facility Name (If not institution,	_				own, or Loc	ation of De	eath		4c. C	ounty of De		
			Montgomery General Security Number			last birthday)	If Under 1	ney Year I If I	Jnder 24 H	Hrs.	8. Date of Birt	h	Montg	omery inhplace (State o	v Foreign
	Funeral Director		212-43-9797	1 M 2 2 F	-196 (<i>III yi</i> s. 7					Ain.	(Month, Da) 5-15-3	y, Year)	(rea	n i Greigii
			Usual Residence of Decedent				1				<u> </u>				
	nylan how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside Ci	•
	e Ma	cto	MD Montgo	omery	01	ney								1 □ Yes	28 140
	or 2	Director	10e. Street and Number				10f. Zip C						en of What C	Country?	
	s 23a	rai	2100 Olney-San	dy Spring 12. Was Decede		C 12		20832	nic Origin?	2 /\$000	ify Vas or No.	Kore		nerican Indian,	
	Item Iner	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?	.3.	Il Yes, specify	y Cuban, M	exican, Pu	uerto R	ify Yes or No- ican, etc.)		Black, Wh		
920	urs af	ρ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 ☐ Yes 212	⊠ No Sµ	oecify:			S	Specify: A	sian	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23e or 28e-f show other than "natural", or Items 23e or 28e-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual	Occupation	a most of	workin	9	16b. Kind	d of Busines	s/Industry	
2	within and the second s	nple	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT use	retired)							
2	e filed within al Hygiene. other than '	ပိ	12			Home	maker	10	Mothada	Nama	(First, Middle,		home		
and	be fi	Be	17. Father's Name (First, Middle, L	25()				18.				Maldoll	umamo,		
3	should be nd Mental marked	2	Unknown 19a. Informant's Name/Relationshi	in (Type Print)		19b Maili	na Address (Street and I		kno	Wn Route Numbe	er. City or	Town State	. Zip Code)	-
Maryland	id 2 s ith an 27 is:		Edward Kim-Son				•				ver Sp				
	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury oc other traumatic eroce.		20a. Method of Disposition		1 6	Place of Disponentery, crea	sition (Name	e of		Da		- 190 a fr		or Town, State	
Ë	Page ent o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation _5 ☐ Other (Sp.		te I	ıdon Pa			ry 1	-19	-04	Balti	imore,	MD	
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m	\$9 E E 8		of forde	e Wil		1	11800	New Ha	ampsh	ire	Ave.	Silve	r Spr	ing, MD	20904
-	Physician /Medical Examiner	Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events	a. Muli	as a consequence	juence of):	juvis							Interval Bet Onset and I	Death
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.O. Box	at the death certific by the attending pl tached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta t at time of d	al death 3	⊒Ectopic preç ⊒ Other (s <i>pec</i>					23	3d. Date of d Month	-	Year
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Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		Venue		Other			(Check only o		, ,		
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Division	F & F C	Certification	3 Suicide 6 Could n 4 Homicide determin	ned 286. Place of	Injury - At h etc. (Specia	ome, farm, st	1	office	^	2	8I. Location (S City or Tox	Street and vn, State)	Number or I	Rural Route Num	the
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	To the Ho within 24 I To the Fu completely	ž	29b. Signature and title of certifier				29c.	License nu						nth, Day, Year)	
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			31. Date filed (Month, Day, Year)		istrar's Signa		Penn S	Stree	t, Ba	ılti	more,	Mary]	and 2	1201	
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			1 - For State Registrar	State of M			ent of H	lealth and	Mental Hyg	9		02401
	Physic	ian	Decedent's Name (First, Mid						2. Date of Dea Month		Year	3. Time of Death
,	/Medi			Soon Ki					Jan.9,	2004		3:40a м
	Exami	ner	4a. Facility Name (If not instituti)	1		r Location of Dea		4c. County		
			13002 Sunsto					r Spri		_1	tgom	
E	Funeral Director		5. Social Security Number 215-02-0425 Usual Residence of Decedent	6. Sex 1 □ M 2 ▼ F	ge (In yrs. last I 94	Yrs. Mont	hs Days	If Under 24 Hrs Hours Min		^{Year)} 1909		plece (State or Foreign htry)
Maryland	-f show fied at	tor	10a. State 10b. Coun	gomery		wn or Location 7er Spi	ring			· · · · · · · · · · · · · · · · · · ·	1	0d. Inside City Limits 1 ☐ Yes 2X No
adt the	3a or 28a at be not	al Direc	10e. Street and Number 13002 Sunsto	one Court		10f.	Zip Code 2090	4	1	0g. Citizen of \	What Cour	ntry?
OUSO Dougs after death with the Maryland	ital Hygiene. od other then "neture!", or liems 23a or 28a-f show event, Ita Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 XWidowed 4 Divorce	If Yes Give	?		specify Cuba		Specify Yes or No- rto Rican, etc.)	Blac	e - Americ ck, White,	etc.
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V 2	ar th	P.	8		-	Homer	naker			Own	Home	
Mar ylarid 21213-0036	and Mental Hy marked oth umatic svent	To Be	17. Father's Name (First, Middle unknown	s, Last)				18. Mother's Na unknov	me (First, Middle, M WN	Aaiden Surnam	re)	
, Mar	10 m in		19a. Informant's Name/Relation Hwa Kim/Daug			13002	Suns		ural Route Number ourt Sil			code) g,Md20904
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101 2		×	29b. Signature and title of certific	lan		2	29c. License DO	number 021033	29	d. Date signed	(Month, D	
			30. Name and address of person Dr. Byoung Le				re.Si	lver Sp	pring,Md	20906	5	
	Sta Registr	-	31. Date filed (Month, Day, Year		ar's Signature	4 1	sarks.	/				

			1 - For State Registrar	State	of Maryla	nd / Depa	artmen <i>rtificat</i>	t of H e of L	ealth a Death	and M		giene Reg. No.		02495
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	Physici /Medic			ne Montes							January	8,	2004	12:05p ^M
	Examin	er	4a. Facility Name (If not institution 15100 Interlact						Location o				County of De	
			5. Social Security Number	6. Sex		s. last birthday)	1	1 Year			8. Date of Birt		ntgome	irthplace (State or Foreign
	Funeral Director		220.40.5951	1 ☐ M 2 🛣 F	88	Yrs.	Months	Days	Hours	Min.	Oct.5,	ï 913	Wes	t Virginia
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	anylan show	_	10a. State 10b. County		ĺ	City, Town or Lo								10d. Inside City Limits 1 ☐ Yes XX No
	8a-1	Director	MD Montgo	mery	S	ilver S								
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3	ral', o		3XXVidowed 4 ☐ Divorced	If Yes, G Year or	live Dates:		1 🗆 Yes	2XJ No	Specify:				Specify: W	hite
5	72 h	Completed	15. Deceden (Specify only higher		"	16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa nk done d	ition luring most	t of workii	ng	16b. Ki	nd of Busines	s/Industry
7	within ne.	mpi	Elementary/Secondary (0-12)	College	(1-4or 5+)	Ambas						77		
7 ·	Hygie ther t		17. Father's Name (First, Middle,	Last)		Allibas	sador			r's Name	(First, Middle,		ome	71-24-14-14-14-14-14-14-14-14-14-14-14-14-14
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Importment if them 27 is marked other than "natural", or items 23e or 28e-f ehow any injury or other traumatic event, if a Modical Exactival must be notified at once.	To Be	Adelino Mor								na Vald			
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	Pag ment ant: I		*4 □Donation 5 □ Other (S	pecify)	Ro	ock Cre			-)		ington	
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F	Physician /Medical		23a. Pent1. Enter the disease, or shock for fleart failure. List Immediate Cause (Final disease or condition resulting in death)	Cer	each line. ebroVas	cular A			y, such as	Cargiac o	respiratory at	1951,		Approximate Interval Between Onset and Death Weeks
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200	physicate sthe	dic	i	d										
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5 :	eath. or: Al	atic	2 ☐ Accident investig	jation			М		es 2 N	No				
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by t	Certification:	3 Suicide 6 Could i	ined 289. Plac	e of Injury - At h ding, etc. (Speci	nome, farm, str ify)	eel, factory	, office		2	8f. Location (S City or Tow			ural Route Number,
;	Hosp 24 hou Fune etely fil	edical	29a. Certifier XXCertifyin (Check only one) 2 Medical	g Physician: To th Examiner: On the l and mar	e best of my kn basis of examinations	owledge, death ation and/or inv	n occurred a vestigation,	at the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the o	ause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	ro the	Me	29b. Signature and title of certified		0		29c	License	number		2		signed (Mon	
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	and the same of th		30. Name and address of person		use of death (Ite	m 23a) (Type,	Print)	4- D		01	14	-1	1 0000	10
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			1 - State Registra AVEND#18peri	State of N	/larvlar	nd / Depa <i>Cei</i>	artmer	nt of H							1,06
			Decedent's Name (First, Middle)								2. Date of De	eath			ne of Death
п	Physici		Clotile Nancy	Knight							Month Januar	y 9,	2004		.5 A M
2	/Medic Examir		4a. Facility Name (If not institution,	give street and number);)		4b. City.	Town, or	Location of	of Death		4c. (County of De	ath	
п			Washington Adv	entist Hosp	oital		Tai	koma	Park			Mo	ntgom	ery	
	Funeral Director		267-48-9443	6. Sex 1 ☐ M 2 ☒ F	Age (In yrs. 66	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di April	th Year)	9. B	inthplace (Sta Country) Lorida	ate or Foreign
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Insid	le City Limits
	f sho	ō	Maryland Montg	omerv	Si	lver S	Spring	7						1)(2)	Yes 2 □ No
	28e-	Director	10e. Street and Number					Code				10g. Citiz	en of What (Country?	
	3a or		13123 Broadmor	e Road			209	904				Unit	ed St	ates	
	death	nera	11. Marital Status	12. Was Deceder Armed Forces		.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)			nerican India	n,
920	be filed within 72 hours after death with the Maryland lat Myglene. do dher than "netural", or items 23a or 28e-f show of other than "netural", or items 23a or 28e-f show event, it a Medical Examinatinal Le multiple at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Torocced		No		1 ☐ Yes		Specify:	i, Fuelto	ricall, etc.)	ŀ	Specify: B		
Q Q	72 ho	Completed	15. Decedent' (Specify only highest			16a. Dece	deni's Usu	al Occupa	ition Juring most	of worki	na	16b. Kin	d of Busines	s/Industry	
2	ithin 19	nple	Elementary/Secondary (0-12)	College (1-4o	or 5+ <u>)</u>				luring most)		.3	D 0	D 11		1
2	ygien ygien yer th	Co			5+	Coun	selo	<u> </u>	40.14.0		W			ic Sch	1001
Maryland 21215-0036	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked out any injury or other traumatic even once.	To Be	17. Father's Name (First, Middle, Lunknown	ast)					18. Motha E11:	ITa Mac	(First Middle Mae Rozie	Dav Dav r Dav	Vis		
an.	2 sho and is mu		19a. Informant's Name/Relationsh								l Route Numb	-		, Zip Code)	
	and ealth m 27		Rosetta Evans	(sister)	001- 5						ami, F			127	
0	Pages 1 nent of H nnt: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 X iRemoval from Stat	le	Place of Dispo cemetery, crer								or Town, Slate	в
Ē	Part tent:		`4 □Donation 5 □Other (Sp	ecify)	Da	de Mem				1/21/	04	Miam	i, Fl	orida	
Baltimore,	Depar mpor mp in in y in		21. Signature of Funeral Service L			M	cGuiı	e Fu	s of Facility neral	. Ser	vice				
	40290		and Estarthadisesses or	amplications that cause	ad the deat	7	400 (Georg	ia Av	re. N	.W. W	ashin	gton,	D.C.	
			23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final	nly one cause on each	line.	ii. Do not ent	er trie mot	ae or dysng	y, such as	cardiac	i respiratory a	11031,		Interval	Between and Death
	Physician /Medical		disease or condition resulting in death)	a Hypox											
ŀ	Examiner			Due to (or a			++	م گرین							
4	2	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a		ung Me	Lasta	ISLS							
	ate be executed sysicien and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Breas	t Can	cer									
Ċ.	le be executed ysicien and e burial-transit	Exa	resulting in death) Last	Due to (or a	as a conseq	uence of):									
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68		led	IF FEMALE:												
õ	eath certific attending p	by Physician/Med	23b. Was decedent pregnant	23c. If yes, outcom			Ectopic p	regnancy				23	d. Date of d Month	elivery Day	Year
.O. Box	at the dea by the at tached fo	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eath 5□	Other (sp	pecify)					WORKI	Day	1 001
<u>Р</u>	d by t	Phy	Part II. Other significant condition	ne contributing to death	but not rec	ulting in the u	nderh/ing (auce awa	on in Part I		23e Did 1	tohacco usi	e contribute	to the cause	of death?
Vital Records,	rres that signed to 1 be det	by	Acute Renal Fa	-	Dut not 165	alting in the di	indeniying c	ause give	ni iii Faiti.					Probably 4	
0	w require been si should t	etec													
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a	r: Th										1 ☐ Yes	2X□ No		s 2 No	
Ë	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		50:0		Cthe	r		(Check only				
ō	Phys rthis ral di	i: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 LX Inpa		ER/Outpatien 28b. Time of)A	4 🗌 Nui		ne 5 Resi			ecify)	
on	ding th. Afte fune	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investig		Day Year)	Injury	м	8c. Injury Work 1 □ Y	? ′es 2 ∐ h			. ,			
Division of	Atten r dea ctor by the	Certification:	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of I	njury - Al h	ome, farm, str	eet, factor	, office		- 2	8f. Location (Number or F	Rural Route N	lumber,
á	al or after	erti	4 Homicide	building,	etc. (Specif	Y)					City or To	wn, State)			
	To the Hospitel or Attending Physicien: white 24 hours after deals at the found to the Funeral Director. After this certifica completely filled in by the funeral director, to	Medical O	29a. Certifier 1 X Certifying (Check only one)	Physician: To the best xaminer: On the basis and manner:	of examina	wledge, death tion and/or inv	n occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a	ind due to the ad at the time,	cause(s) a date and p	nd manner a lace, and du	as stated. le to the caus	se(s)
	roth within roth ompl	Me	29b. Signature and title of certifier	17/1			290	c. License	number			29d. Date	signed (Mor	nth, Day, Yea	r)
	10		*	16/			-	47	P6-	7		Janua	ry 10.	2004	
	10		30. Name and address of person w	no completed cause of			Print)								
			DR. ONLY	ZUNICA				ph R	oad,	Rock	ville,	MD :	20852	Ste: i	#101
gran.	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 13	32. Regis	strar's Signa	ture &	Sp	acks							

			1 - For State Registrar			d / Depa	artmei	nt of H				iene	. 0240	1 -7
			Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	th	3. Time of Dea	ath
	Physici /Medic		S	Sylvia Ber	tha K	RASOW						Day Ye. 11. 2004	6:55 P	М
1	Examin		4a. Fecility Name (If not institution, giv	street and number)			4b. City	, Town, or	Location of			4c. County of D		
			Hebrew Home of Gi					lockv				Montgo		
	Funeral		5. Social Security Number 6. S	ex 7. Ag □ M 2□XF		a <i>st birthday)</i> Yrs.	Months Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day		Birthplace (State or Fo Country)	
	Director		046-09-9418 Usuai Residence of Decedent		88					1	Mar. 16	, 1915 C	onnecticut	
	iand ow		10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City L	imits
	Man H	ţō	Maryland Montgo	mery		Rocl	kvill	.e					1 Tyes 2	ŽΝο
	s 1 and 2 should be fited within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, its Mudical Exaction minist he indiffed at	ai Director	10e. Street and Number 6105 Montrose Roa	ıd #1135E	1		10f. Z	p Code	20852	2	1	Og. Citizen of What United S		
	deed deed	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		6. 13.	Was Deci	edent of Hi	ispanic Orig	jin? (Spec	cify Yes or No-		merican Indian, /hite, etc.	
21215-0036	ours after rail, or ite	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 Tr If Yes, Give Year or Dates:			1 □ Y <i>e</i> s		Specify:			Specify:	white	
5-0	72 hc	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece	kind of w	ork done o	during most	of workin	g	16b. Kind of Busine	ss/Industry	
121	vithin han	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		<i>bo not</i> kkeep	use retired er)			Variet	У	
Maryland 2	2 should be fited within 72 hours after and Mental Hygiens, and Mental Hygiens, is marked other than "natural", or surnatic event, it a Mudical Exercit	Be	12. 17. Father's Name (First, Middle, Last	Samuel Blu	menfe	1d		-	18. Mother		(First, Middle, a Oline)	Maiden Sumame)		
2	hould d Mer mark mark	2	19a. Informant's Name/Relationship (Tyne Print)		19h Mailir	na Addres	s (Street a	and Number	r or Rural	Route Number	, City or Town, Stat	e. Zin Code)	
Ma	id 2 s lith an 27 is trau		Minka Goldstein,								omac, M			
<u>o</u>	permit. Pages 1 and 2 Department of Health & Important: If item 27 is eny injury or other tra		20a. Method of Disposition		20b. Pla	ace of Dispo metery, crei	osition (Na	ame of			ate	20c. Location - City	or Town, State	
e E	Page onto		1 Denial 2 Cremation 3 C 1 Donation 5 Other (Special		1	Lebar			1	01/12	2/04	Adelphi,	MD	
Baltimore,	mit. I partm porter / inju		21. Signature of Funeral Service Lice		, 110 0	22	2. Name a	and Addres	s of Facility	/				
m	Depar Impo				\ni	2	sreni 54. Ca	usky vrol	nebre 1 St	NU PU	merai i Washi	Home, Inc	· - 20012	
	Physician		23a. Pant Enfer the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting is death).	plications that cause one cause on each li	d the death. ine.	. Do not en	ter the mo	de of dyin	g, such as d	cardiac of	respiratory arr	est,	Approximate Interval Betwee Onset and Deal	n ith
	/Medical Examiner		resulting in death)	Due to (or as		1	7.							
3		-er	Sequentially list conditions,	b. Due io (oi as	a consequ	hyp.	v Yeh.	ica						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Arr	ti s	tenosis	5							
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P.O. Box	The law requires thet the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	□Ectopic □ Other (s	pregnancy specify)				23d. Date of Month	delivery Day Year	r
٦	signed by	y P	Part II. Other significant conditions	contributing to death b	out not resu	lting in the u	inderlying	cause give	en in Part I.		23e. Did to	bacco use contribut	e to the cause of death	h?
Records,	quires n sign	d b	Alz heineri	Distale							1 🗆 Y	es 2□No 3□	Probably 4 donkr	nown
Ö	s been si should!	olete									24a. Was a		autopsy findings avai	
Re	The la	E									autops perfor	ned? deatl	to completion of cause 1? ∕es 2□ No	9 ():
ita		BeC	25. Was case referred to medical						26. Place	of Death	(Check only or			
>	Physician: this certific ral director,	ToE	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	ER/Outpatier	nt 3 🗆 🛭	OA Oth	er: 4 Nur	rsing Hom	ne 5□Reside	ence 6 Other (S	Specify)	
Division of Vital	of fe		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ay Year)	28b. Time o Injury	M M	28c. injury Work 1 🗆 '	/at k? Yes 2 □ N		8d. Describe h	ow injury occurred		
Divis	al or Atte after de Diracto d in by th	Certification:	3 Suicide 6 Could not to determined	288. Place of in	jury - At hoi tc. <i>(Specify</i>)	me, farm, st	reet, facto	ory, office		2	8f. Location (S City or Town		Rural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funerel Diractor: A completely filled in by the fu	Medical C		nysician: To the best miner: On the basis of and manner st	of examinati									
	To th Within To th	Me	29b. Signature and title of certifier	ζ			2	9c. License	e number		2	9d. Date signed (M	onth, Day, Year)	
7	70		Hay 3 W/W	h ms				D55	250	2		Januar.	2,2004	
			30. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print)		9		,		1	
			31. Date filed (Month, Day, Year)	1.17. 6121	mon	TRESU	Rel	10	Kocku	nece	MARY	LAND 3	20852	91
1	Sta Regist		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ture /	10	aks					onth, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	For State Registrar	State of M		Certificate o			Reg. No.	111	II X III ar ya
		1. Decedent's Name (First, Middle, La	st)				2. Date of De	aath Day	Year,	3. Time of Death
hysici Medio/		JOYCE A. LO	NG				/		004	1105
Examin		4a. Facility Name (If not institution, giv		1 40/	4b. City, Town	or Location of Dea	ith		ty of Death	
		PENINSULA REGIO	///	CON CENT	311	USBUM			(com)	
uneral rector		221-28-81/8		e (In yrs. last birth	Months Day			th ay, Ye <i>ar)</i> 1944	9. Birthp Cour DELA	
¥		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					0d. Inside City Limi
d ab	ō	DELAWARE SUSSEX		FRANKF						1 ☐ Yes 2 ₩
28a Double	Director	10e. Street and Number		FIMINIT	10f. Zip Code			10g. Citîzen o	f What Cour	ntry?
30 0		RR4 BOX CA7			1994	;		US		
E E	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent o	**	Specify Yes or No)- 14. R	ace - Americ	
or fte	正	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🕅	No	1 ☐ Yes 2 X N		nto mican, etc.	Spec	lack, White,	ITE
LEXE.	d by	3 Widowed 4 Divorced	Year or Dates:							
"nati	iete	15. Decedent's E (Specify only highest gra		1 (ecedent's Usual Occ Give kind of work dor ife. DO NOT use reti	e during most of w	orking	16b. Kind of	Business/In	dustry
Da M	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	ENTORY DEL		RSON	NYLON	PRODU	CTION
od other than "natural", or Itema 23e or 28e-f ahow avent, the Medical Examinar must be notified at	e C	17. Father's Name (First, Middle, Last,)	1 221 7	DICTORY DEL		ame (First, Middle,	, Maiden Suma	ame)	
Ked o	To B	JACOB ATKINS					HITCHENS			
tem 27 is marked other traumatic av	-	19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Address (Stre	et and Number or F	Rural Route Numb	er, City or Tow	n, State, Zip	Code)
m 27 is her trau		WAYNE E. LONG/ H	USBAND	RR4	BOX CA7,	FRANKFOR	D. DE. 1	9945		
Item		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other p		Date	20c. Location	n - City or To	wn, State
ant: if its		1 🕅 Burial 2 □ Cremation 3 □ `4 □ Dopation 5 □ Other (Specif			ORO CEMETE		4-04	MILLSB	ORO, DI	ELAWARE
in in	Ì	21. Signature of Puneral Sector Live	nsee	-0.	MELSON FO	INFRATILITYSE				
any ii		1 6 3 /4	Clan		THATCHER				19945	
physician and the burial-transit	cal Examiner	Sequentially list conditions. If any, leading to intrinectate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of				N		
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signed d be de	þ	Part II. Other significant conditions of PRLOPL (contributing to death b	ut not resulting in t	he underlying cause (riven in Part I.		obacco u <i>s</i> e co Yes 2 □ No	ntribute to th	ne cause of death? ably 4 Unknow
peed	ompieted	BRAINSIE	M GD	FMA			24a. Was		. Were auto	psy findings availat
s b	mo						autor perfo	psy prmed? 2 No	prior to condeath?	npletion of cause o
te has age 2	e C	25. Was case referred to medical				26. Place of De	eath (Check only o		1 1 103	20140
ate has page 2	0 8	examiner? 1 □ Yes 2 □ No	Hospital: 1Inpatie	ent 2 ER/Outp	atient 3 DOA	ther	Home 5□ Resid		ther (Specifi	()
is certificate has director, page 2		27. Manner of Death	28a. Date of Inju	ry 28b. Tir y Ye <i>ar)</i> Inj	ıry W		28d. Describe I			
After this certificate has funeral director, page 2	tion: T	1 Natural 5 ☐ Pending								
ior: After this certificate has the funeral director, page 2	ertification: T	1 Natural 5 ☐ Pending	n 28e. Place of Inj	ury - At home, farn c. (Specify)	n, street, factory, offic	9	28f. Location (S City or Tox		nber or Rura	l Route Number,
Funeral Director: After this certificate has ely filled in by the funeral director, page 2	dical Certification: T	1 Natural 5 Pending investigation 3 Suicide 4 Homicide Certifying Pt	28e. Place of Inbuilding, et	c. (Specify) of my knowledge, and/	n, street, factory, offic	time, date and plac	City or Tou	wn, State)	nannar as si	ated
Funeral Director: After this certificate has ely filled in by the funeral director, page 2	Medical Certification: T	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Exer	28e. Place of Injuding, et	c. (Specify) of my knowledge, and/	n, street, factory, officed at the or investigation, in my	time, date and plac	City or Tow ee, and due to the curred at the time,	wn, State)	nanner as si e, and due to	ated. the cause(s)
Director: After this certificate has in by the funeral director, page 2	edicai	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 5 Pending investigation 6 Could not b determined	28e. Place of Inbuilding, et	c. (Specify) of my knowledge, and/	n, street, factory, officed at the or investigation, in my	time, date and place opinion, death occ	City or Tow ee, and due to the curred at the time,	cause(s) and n	nanner as si e, and due to	ated. the cause(s)
Funeral Director: After this certificate has ely filled in by the funeral director, page 2	edicai	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Place of Inbuilding, et	of my knowledge, of examination and/	death occurred at the or investigation, in my	time, date and place opinion, death occ	City or Tow ee, and due to the curred at the time,	cause(s) and n	nanner as si e, and due to	ated. the cause(s)

		1 - For State Registrar	State of Maryland		ent of Health and late of Death		ene)	02499
Physic /Medi		Decedent's Name (First, Middle, Last) Norris Owen Let	vis			2. Date of Death January	łð, 20ŏ4	3. Time of Death
Exami		4a. Facility Name (If not institution, give s		4b. C	ty, Town, or Location of Death Cambridge	1	4c. County of Death	nester
Funeral Director		Dorchester General 5. Social Security Number 6. Sex 1218-18-3635	M 2 F 90	ast birthday) If Un Yrs. Mont	der 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Aug. 14	Year) 9. Birth	place (State or Foreign intry) aryland
aryland show	J.	Usual Residence of Decedent 10a. State 10b. County		, Town or Location				10d. Inside City Limits
r 28e-f	Irecto	Maryland Dorchest 10e. Street and Number	ter	Wing	ate Zip Code	10	g. Citizen of What Cou	
ath with	raD	2015 Wingate-Bish			21675		USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28e-f show important: if item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event. I're Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.3 Amed Forces 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
72 hou natura Jical E	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's U	sual Occupation work done during most of wor Tuse retired)	rking 1	6b. Kind of Business/l	
within ane. then	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	Wate:			Shellfish	1
12 should be filed within h and Mental Hygiene. 7 is marked other then traumatic event, Ir.e M	Be Co	17. Father's Name (First, Middle, Last)		wate	18. Mother's Nar	me (First, Middle, M	laiden Sumame)	
ould b Menta	To.	James Matthew Lew			ess (Street and Number or Ru	y Windson		- Co-(t)
and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Tyri Eastland M. Lewis			ngate-Bishops			
ges 1 a of Hec or othe		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	lace of Disposition (emetery, crematory	or other place)		Oc. Location - City or 1	
it. Pages rtment of l rtant: if it		'4 ☐ Donation 5 ☐ Other (Specify) 21. Sign rure of Funeral Sevene License	Dot	rchesterM	emorialPark 1	/14/2004_0	Cambridge,	MD
permit. Departr Importa any inj		1 Aloo a Albana	4 monus	ell 308	and Address of Facility an-Bromwell Fu High St., Camb	ıneral Ho	me, P.A. D. 21613	
Pnysician		23a. Part1 Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition		Do not enter the revolute	node of dying, such as cardian	or respiratory arre	st,	Approximate Interval Between Onset and Death
/Medical Examiner	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence to (or as a consequence)	uence of): A	tery Dise	cse		
cate be executed physician and the burial-transit	dlcal Examin	Cause Diseases of Injury that initiated events resulting in death) Last	Due to (or as a consequ	-	we			
w requires that the death certificate been signed by the attending phys should be detached for use as the	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopi	c pregnancy (specify)		23d. Date of deline Month	very Day Year
law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not resu	ulting in the underlyin	g cause given in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2 No 3 Pro	the cause of death? bably 4 □Unknown
2 5	Completed	(1)				24a. Was ar autopsy perform 1 Yes 2	prior to death?	topsy findings available ompletion of cause of 2 No
Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 146	ospital: 1 mpatient 2 🗆	ER/Outpatient 3□	Othor	ath (Check only one	nce 6 ⊡Other <i>(Spe</i> c	
ding Phys h. After this funeral di	H	27. Manner Death 1 Chatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho		ar y)
To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fac	ctory, office	28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
Hospi 24 hou Funer	edical		sician: To the best of my kno- ner: On the basis of examinal and manner stated.					
To the within;	Med	29b. Signature and title of certifier			29c. License number		d. Date signed (Month	Day, Year)
		* Balto n	1·D		D0057040 t. Cambri) (1/11/20	04
		30. Name and address of person who co		23a) (Type, Print)	Combo	doc ha	D 2161	2
		KE DATE TO PETE TO		rora s	· (CAMINY	acde no	יטי	5

			1 ⊷ For State Registrar	State of M	laryland		rtmen <i>tificati</i>			nd Me		giene Reg. No.	2001	. 025	100
	- Physici		Decedent's Name (First, Middle, L RAYMOND E. LANG	_ `							Date of De Month	Day			4.4
4	/Medio Examin		4a. Facility Name (If not institution, g 3811 Inverness I		·)		4b. City,		Location of	Death	THOM()	4c.	County of D	eath	Α
Marie Control	Funeral Director		131-03-7784	Sex 7. A 1☐XM 2☐ F	ge (In yrs. lasi	t birthday) 3 Yrs.	If Under Months		If Under 2 Hours	Min. 8	Date of Bir (Month, Da ec.9, 1	th y, Year)	9. E	Birthplace (State Country) W York	or Foreign
	Maryland B-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgor	mery	10c. City, T	Fown or Lo								10d. Inside C	ity Limits
	with the 3a or 28	I Director	10e. Street and Number 3811 Inverness I	rive			10f. Zip	Code 0815				-	zen of What	-	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "netural", or items 23e or 28e-f ehow many injury or other traumatic event, the Medical Examiner must be notified at ODGE.	by Funeral	11. Marital Status t ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1	? No		Vas Deced f Yes, spec		spanic Orig n, Mexican, Specify:	in? (Speci Puerto Ric	fy Yes or No can, etc.))-		merican Indian, hite, etc.	
Maryland 21215-0036	d within 72 ho giene. Ir then "netu	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)	16a. Deced (Give life. L	kind of wor DO NOT us	rk done d se retired)	u <i>ri</i> n <i>g most</i>				nd of Busine	ss/Industry	
yland ;	should be filed and Mental Hyge marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Lat Charles Litovit	st) Z					18. Mother Esthe	's Name (/ er Lu	First, Middle, ubetki	n			
	and 2 sho salth and n 27 ie m		19a. Informant's Name/Relationship Sylvia B. Long -								Route Number			a, Zip Code) and 2081	15
Baltimore,	Pages 1 and the ment of the mit: If the mary or other		20a. Method of Disposition 1		20b. Plac cem	e of Disponence of Davi	sition (Nan natory or o	ne of ther place)	Date	е	20c. Lo	cation - City	or Town, State	
Balti	permit. Departr Imports any inji		21. Signature of Fureral Service Lic 23a Pent 1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	ad the death.	DO 44	Name an nald 00 Pc	d Addres V. B wder	s of Facility Orgwa Mill	rdt F Road	unera Belt	l Hon		A. ryland Approxima Interval Be	20705
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Can	cer of			-						Onset and 1 yea	Death BY
o,	rate be executed ohysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequent									15 yea	us
68760,	rtificate be ex ng physician as the buria	Medical	IF FEMALE:	d											
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Medlcal	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Fetal de at time of deatl	ath 3	Ectopic pro					2	23d. Date of o Month		Year
	n requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions	contributing to death	but not resultir	ng in the ur	nderlying ca	ause give	n in Part I.				_	to the cause of Probably 4	
al Reco	tician: The law r certificate has be rector, page 2 sh	Completed								_	24a. Was autop perto 1 Yes	rmed?	prior t death	autopsy findings o completion of ? es 2 \(\text{No}	available cause of
Division of Vital Records,	ding Phys h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	Hospital: 1 Inpat		VOutpatien Bb. Time of Injury		Bc. Injury Work	r: 4 🗆 Nur:	sing Home	Check only of 5X Resid. Describe h	dence 6		pecify)	
Divis	tal or Attenors after deatles by Director:	Certification:	3 Suicide 6 Could not determine	d 28e. Place of Ir	njury - At home atc. (Specify)	a, farm, stre	eet, factory	, office		28f	f. Location (S City or Tox			Rural Route Nur	nber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 ★ Certifying I 2 ★ Medical Ex	Physician: To the bes aminer: On the basis and manners	or examination	edge, death and/or inv	occurred a restigation,	at the time in my op	e, date and inion, death	place, and occurred	d due to the at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)
•	A Vointhing Company	M	29b. Signature and title of certifier	hors				License	number 28369	-VA			e signed (Mo ry 12,	nth, Day, Year) 2004	
_	<i>U</i>		James Kent M.D.	completed cause of 2200 Opit	death (Item 23	3a) (Type, I	Print) dbrid	lge,	VA 2	2191					
- - 23 75	Sta Registi		31. Date filed (Month, Day, Year) JAH 13 2	32. Regis	trar's Signature	4	Spo	uls	/						